

Wisconsin Family Care Program EQRO Annual Report 2003

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Executive Summary

The Department of Health and Family Services (DHFS) has contracted with MetaStar, Inc. (MetaStar) to conduct external quality review (EQR) activities for the Family Care program. The purpose of EQR activities is to evaluate the services that are arranged for or provided to Family Care enrollees or potential enrollees under the contracts the DHFS has entered into with the care management organizations (CMOs) and the resource centers. EQR activities also help identify how CMOs have implemented systems and processes that are effective in helping members meet their personally defined outcomes. The ultimate goal of EQR activities is to gain an understanding of how each CMO is or is not meeting the needs of its enrolled population, how each resource center and/or enrollment consultant is meeting the needs of potential Family Care enrollees, and how differences in CMO, resource center or enrollment consultant approaches are affecting member outcomes.

EQR activities have a multi-faceted approach to assuring that these objectives are met, while focusing on assisting members to identify and achieve their personal outcomes. Contracted quality efforts in 2003 included:

- Conducting regular quality on-site visits with each resource center and CMO;
- Assuring integrity of the Long-Term Care Functional Screen by reviewing results of inter-rater reliability testing;
- Interviewing CMO members about their individual preferences and outcomes;
- Assisting CMOs in planning for and conducting focused quality improvement projects;
- Validating the CMO reported performance measures;
- Monitoring the CMO Plan of Care development process;
- Reviewing CMO reported unexpected deaths; and
- Investigating appeals and grievances reported to the Department.

The EQR process is intended to be a collegial interaction with the goal of improving the quality of health and long-term care services provided to Family Care members and potential members.

The Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services Quality Framework served as a uniform format for integrating the findings of each of the 2003 EQRO contracted quality reviews. Key findings from each domain of the CMS framework addressed in the attached report are highlighted below.

- **Participant Outcomes and Satisfaction:** CMOs seem to have embraced the concept of identifying member outcomes during the assessment process and using these outcomes to direct service planning. Member outcome interviews however, showed that approximately 29 percent of members interviewed did not achieve satisfaction with their services or that supports were not in place to help members achieve satisfaction with their services. Quality site review findings confirmed that most CMOs do not have a mechanism in place to solicit member feedback, such as a satisfaction survey.

- **Participant Access:** Review findings suggested that most resource centers appear to have timely and accountable systems for enrollment; however enrollment can still take more than 30 days. Baseline studies for options counseling and reasons for disenrollment from Family Care were also conducted in 2003. Findings from these studies support recommendations that include developing guidelines and refining staff trainings to enhance the current process for options counseling. Other recommendations include the collection of data on reasons for disenrollment, which could help resource centers identify opportunities for program improvement. DHFS should consider expanding both of these studies in 2004.
- **Participant Safeguards:** CMOs have made progress in implementing safety and risk policies. However, member outcome interview results, along with several other review findings related to health and safety suggest that there are still opportunities to improve services and supports that contribute to members' overall health and well being. The findings suggest that CMOs may need to further define and expand their vision of the RN role in the Family Care model.
- **Provider Capacity and Capabilities:** All CMOs should continue to develop processes to systematically monitor provider performance. Information obtained through quality program activities, utilization management data, and appeal and grievance data will assist in evaluating provider capacity and capabilities to provide quality services to Family Care members.
- **Participant Rights and Responsibilities:** Some improvements related to CMO internal grievance systems were noted across most CMOs in 2003. While the organizational culture of each CMO appears to support member rights and fair treatment, findings from quality site reviews and MCAP reviews suggest that providing information to members on how to access the grievance system continues to be a challenge. This may be evidenced by the fact that only one grievance was filed in 2003 related to member rights. Inconsistent use of the Notice of Action form can inhibit members from exercising their right to file an appeal or grievance. All CMOs need to further develop and implement processes that will promote member awareness of their rights as a Family Care member.
- **Participant Centered Service Planning and Delivery:** EQR finding from 2003 suggest that CMOs are involving members in decision- making about services when developing plans of care. However, even with member involvement, common issues for members center on disagreements with authorization decisions and service plans. Inconsistent decision-making processes, discomfort in communicating negative decisions, and negotiating skills of the interdisciplinary teams may have contributed to the lower percentages for member outcomes and supports related to service planning and delivery. Another area that may be affecting member outcomes related to service planning is the timeliness in which service planning occurs, along with the time it takes to authorize and implement services. DHFS should consider collaborating with the CMOs to develop guidelines for consistent application and documentation of the established Resource Allocation Decision- making tool. DHFS should also consider periodic review of timeliness standards related to CMO service planning and delivery function.
- **System Performance:** All CMOs successfully collected valid data regarding immunization and turnover rates in 2003. Each CMO had produced written documentation of internal processes, which supported the reporting of valid data.

Developing performance improvement projects continued to be a challenge for CMOs. DHFS, MetaStar and the CMOs worked cooperatively to find an acceptable model of improvement. In 2003, the Center for Health Care Strategies (CHCS) 'Best Clinical and Administrative Practices'

model was adopted for use by all CMOs. Currently, each CMO has implemented performance improvement projects using this model. DHFS and MetaStar should continue to provide ongoing training and support in the application of this model for quality improvement in Family Care.

The report details all EQR activity conducted by MetaStar in 2003 for the Family Care program across all CMOs and resource centers.

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Introduction to the Family Care Philosophy

As a comprehensive and flexible long-term care service system, Family Care strives to foster people's independence and quality of life, while recognizing the need for interdependence and support. The Family Care initiative encompasses four main goals:

Choice: Give people better choices about the services and supports available to meet their needs.

Access: Improve people's access to services.

Quality: Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.

Cost-Effectiveness: Create a cost-effective long-term care system for the future.

The focus on member choice is one of the key Family Care initiatives.¹

Family Care currently operates in five Wisconsin counties as Care Management Organizations (CMOs) and nine Wisconsin counties as resource centers. The following table lists the counties that currently operate resource centers and/or CMOs:

Family Care Counties	
Resource Centers	Care Management Organizations
Richland	Richland
Milwaukee	Milwaukee
Portage	Portage
Fond du Lac	Fond du Lac
La Crosse	La Crosse
Jackson	
Trempealeau	
Marathon	
Kenosha	

As the entry point into the complex long-term care system, resource centers in Family Care are expected to develop a breadth of programs and services to meet the needs of a diverse consumer base. In order to meet the challenge of informing and assisting a wide variety of consumers, and to break from DHFS' practice of prescriptive, contract-specific program requirements, the resource centers are expected to operate under the principles of continuous quality improvement.

¹ Information about the Wisconsin Family Care Program was obtained from the DHFS website (<http://www.dhfs.state.wi.us/lcicare/>).

The five CMO counties provide services for the frail elderly, physically disabled and developmentally disabled Medicaid populations. The following table shows each CMO's enrollment numbers, by target group, as of December 31, 2003:

County	Elderly	Developmentally Disabled	Physical Disabilities	Target Group not Recorded	Total
Fond du Lac	462	321	129	1	913
La Crosse	575	443	481	3	1502
Milwaukee	4724	12	57	21	4814
Portage	338	205	131	0	674
Richland	125	94	64	0	283
TOTAL	6224	1075	862	25	8186

In order to assure access to services, CMOs develop and manage a comprehensive network of long-term care services and supports, either through purchase of service contracts with providers, or by direct service provision by CMO employees. The CMO's primary role in Family Care is to locate and make services and resources available that are consistent with Family Care members' preferences. Members are to take an active role in decision-making regarding the long-term care and health care services they need to live as independently as possible. CMOs are responsible for assuring and continually improving the quality of care and services consumers receive.

Defining and Measuring Quality in Family Care

Defining and measuring quality in Family Care is an ongoing process. The concept of measuring quality by measuring member outcomes is central to the Family Care philosophy. All other EQR activities are linked directly and/or indirectly to member outcomes.

Resource Center Quality Activities

In 2003, information regarding Family Care resource centers was gathered from the following sources:

- 2003 quality site reviews that discussed enrollment, information and assistance, options counseling, and marketing and outreach;
- Resource centers' quarterly reports;
- DHFS statistical reports;
- Research studies and analyses commissioned by DHFS; and
- Inter-Rater Reliability Testing (IRRT) results

Inferences and conclusions were drawn by reviewers based on an analysis of the above information.

Member Outcome Interviews

Perhaps the most relevant method of measuring quality in Family Care is by determining whether members achieve the outcomes they expect from the services and supports they receive. During the planning of Family Care, a workgroup of consumers and other stakeholders identified 14 personal outcomes that CMOs would assist members in achieving. These 14 outcomes have provided a basis for measuring quality in the Family Care program.

With subcontracted consultation and staff from The Council on Quality and Leadership (The Council), 491 CMO members were interviewed during 2003 along with their care managers and/or nurses, and determinations were made on what is important to members in their lives and what support exists from the CMO to help members realize their goals.

Upon the conclusion of the third round of member interviews conducted in 2003, the CMO directors met with staff from DHFS, The Council, and MetaStar during a "Strategic Thinking Retreat", to discuss and understand the results of the interviews (Appendix A). This meeting provided the platform for subsequent CMO Director Meetings to focus on the definition of quality as it relates to member outcomes. Discussions were held regarding the development of an Outcomes Workgroup, and plans are underway for development of this workgroup in 2004. This workgroup will continue to identify and define the outcomes that could be considered "foundations" or "basic assurances" – outcomes that need to be in place to assure the health and safety of Family Care members. These four outcomes are:

- People have the best possible health
- People are safe
- People are free from abuse and neglect
- People experience continuity and security

The CMO directors, in collaboration with DHFS also revised the Family Care program mission statement to more clearly reflect the significance of the 14 Family Care outcomes.

Quality Site Reviews

Another approach to measuring quality in Family Care is the Annual CMO and resource center Quality Site Review, which highlights accomplishments and areas of excellence within the CMOs and resource centers that are effective in helping members meet their outcomes, while ensuring that state and federal requirements are met for monitoring quality in the Family Care program. For the 2003 annual site reviews, MetaStar proposed using the Appreciative Inquiry process to assess the CMOs' implementation of quality standards. The focus of this process is to value the successes of the organization in order to support the application and replication of those successful circumstances in the future.

To assist in conducting EQR activities at the five CMOs, review criteria were established and agreed upon by MetaStar and DHFS, then forwarded to each CMO in advance of all on-site reviews. In addition, CMO policies and procedures were reviewed, discussions were held with CMO staff about current processes, members and providers were interviewed to determine their level of satisfaction with Family Care, and data reported to DHFS was verified when indicated.

On-site quality reviews consisted of a pre-visit conference call with the CMO management staff, an on-site visit with CMO staff, and a formal exit conference call to discuss findings. During the on-site visit, discussions were held with CMO case managers, nurses, administrative staff (CMO Director, Provider Network Developer, QA/QI Coordinator, Grievance Coordinator, and case management supervisors), members and providers. Interviews were conducted with staff groups, and consisted of an interactive exchange of information related to each of the following focus areas:

- Availability of Services and Establishment of the Provider Network
- Continuity and Coordination of Care
- Coverage and Authorization of Services
- Grievance Systems

Member-Centered Assessment and Plan Reviews

Member-centered assessment and plan (MCAP) reviews are another approach to assessing and measuring the quality of services and supports provided to Family Care enrollees. The overall purpose of the MCAP review is to evaluate whether standards specified in DHFS' contract with CMOs are being followed and to assure the health and welfare of Family Care enrollees. In general, MCAP reviews are seen as a way to support CMO activities that aim to identify opportunities for improvement in the delivery of care and services to CMO members.

MCAP review findings aid DHFS in learning how each CMO is using the assessment and planning process as a means to work jointly with members to identify members' desired outcomes and to provide supports needed to help achieve those outcomes. Information obtained from MCAP reviews can help in determining the following:

- Whether the CMO identifies member preferences and member-defined outcomes during the assessment process.
- Whether care plans are developed around member preferences and member-defined outcomes.

- Whether services and supports that are identified as important in helping members achieve their personal outcomes are offered and arranged for members.
- Whether services and supports are offered and/or provided to members in a timely manner and whether those services and supports are reassessed periodically to determine if they are effective in helping members to achieve their outcomes.
- Whether the CMO assures that foundational supports that contribute to the health and welfare, safety, and continuity of services for members are in place.

In 2003, MetaStar conducted quarterly MCAP reviews on random samples of three groups of Family Care enrollees for each of the five CMO counties. The three sample groups included Family Care members who had been enrolled in the CMO within the prior quarter, targeted Family Care members who met selected risk factors, and continuing Family Care members who had been enrolled in the CMO for at least one year. When members who were selected for an MCAP review disenrolled from the CMO prior to the review, a disenrollment review, rather than an MCAP review, was conducted. The following table shows the total number of MCAP reviews and disenrollment reviews completed for 2003:

2003 MCAP Review Counts

COUNTY	NEW	TARGETED	CONTINUING	Special Targeted	D/E Review
Milwaukee	29	27	79	1	15
Richland	11	10	14	0	6
Fond du Lac	12	11	48	2	5
La Crosse	12	14	70	1	3
Portage	11	13	38	1	1
TOTAL	75	75	249	5	30
Total MCAP = 404					Total D/E = 30

Review of Unexpected Deaths

DHFS' contract with each CMO requires CMOs to report all critical incidents, including unexpected deaths, to DHFS for trending and analysis. In 2003, DHFS delegated the review of all reported unexpected deaths to MetaStar.

The purpose of reporting unexpected deaths is to heighten the focus on member safety and risk reduction in the service delivery system. While most unexpected deaths are unrelated to health and risk issues or faulty systems of service delivery, fostering open discussion about the circumstance surrounding unexpected deaths can ultimately lead to the creation of safer environments.

Per DHFS' contract with CMOs, an unexpected death is any death that:

- By statute or regulation must be reported to the coroner or medical examiner;
- Is reported to the Department of Regulation and Licensing or any part of the Department of Health and Family Services;
- Is a result of trauma;
- Occurs under suspicious, obscure or otherwise unexplained circumstances; or
- Occurs while a grievance, appeal or fair hearing is pending at the time of death.

The purpose of reviewing unexpected deaths is to identify whether or not preventable circumstances contributed to the death and to make recommendations for actions that address those circumstances and thus help improve the health and safety of all Family Care members.

Appeals and Grievances

In July, 2003, MetaStar was authorized by DHFS to investigate appeals and grievances submitted to DHFS.

Appeals and grievances may be filed by Family Care members or their representatives, at any of three levels. At the local level, members work with their care team or designated CMO person to file an appeal or grievance. At the DHFS level, members file their appeal or grievance directly with DHFS. When members file with DHFS, MetaStar is authorized to attempt a resolution between the member and the CMO. Family Care members can also submit their appeals or grievances directly to the Wisconsin Department of Hearing and Appeals (DHA), where decisions are made by an administrative law judge (ALJ).

The appeal and grievance process relates to the member's satisfaction with the services and supports they receive. When a member does not feel that the service planning and delivery of care is promoting positive outcomes, the right to file an appeal is available to them.

Family Care members file appeals or grievances for several reasons related to the following outcomes:

- Members' preferences of where to reside, including type of facility, or with whom they wish to live;
- Members' satisfaction with services which includes type, frequency and duration of certain services as well as the relationship with their care team;
- Members' ability to participate in the life of the community, including employment and other services;
- Members' ability to choose their services, including frequency and providers of services; and
- Members' feeling of being treated fairly, which is very often the overriding issue when appeals and grievances are filed.

Validation of CMO Reported Performance Measures

Performance measurement validation ensures accuracy and consistency of data reporting across organizations. Consistently produced information is comparable across peer organizations and to industry standards, and can be used to establish both a performance baseline and a target for improvement.

The performance measurement validation process is based upon a collaborative, reciprocal relationship between the validation team and CMO staff. The MetaStar validation team also functions as a support for CMO staff to clarify requirements, serve as a technical resource and process guide, and to address procedural questions or concerns.

Each year, Family Care CMOs are required to collect and report information on certain performance measures. For 2003, these measures were:

- Care management team turnover: Percent of care management team members who separated during the reporting period.
- Influenza Vaccinations: Percent of CMO members who were continuously enrolled in the CMO between September 1, 2003, and December 31, 2003 who received a vaccination during that timeframe.
- Pneumonia vaccinations: Percent of CMO members who were continuously enrolled in the CMO during July 1, 2003, and December 31, 2003 who received a vaccination between January 1, 1993, and December 31, 2003.

It is important to monitor these performance indicators because high turnover rates could reduce continuity of care for Family Care members and insufficient vaccination rates could expose Family Care members to avoidable health risks. As a result, DHFS requires the CMOs to report this information, and directs MetaStar to perform a collegial review of the performance measures for accuracy and reliability and to provide constructive feedback to the CMOs for the purpose of improving monitoring of performance measures.

Performance Improvement Projects

Family Care CMOs are contractually responsible for conducting two performance improvement projects annually. Since the outset of the program, different models and approaches were introduced and tested. No one quality improvement model fit the Family Care program. In 2003 the Center for Health Care Strategies' (CHCS) Best Clinical and Administrative Practices (BCAP) framework was introduced to the CMO directors.

The BCAP model had been used principally in health plans with large memberships. Staff realized that some adaptations would be needed to fully benefit the long-term care work of the CMOs. CHCS was anxious for Wisconsin to try their model in the area of long-term care and offered its support and assistance.

CHCS materials note that BCAP "address(es) the complexities of improving health care services and delivery for people covered under Medicaid managed care." BCAP's stated goal "is to enhance the ability of Medicaid plans to provide quality care within public budgetary limits." The BCAP Quality Framework includes:

- BCAP Typology – Categorizes quality improvement activities in four phases.
- Rapid-Cycle Improvement – Establish measures to evaluate the ongoing progress of activities.
- Measurement and Evaluation – Measure long-term outcomes and evaluate organizational capacity.
- Diffusion and Sustainability – Promote ongoing use of best practices and/or systematic use of BCAP Quality Framework across an organization and/or region.

The BCAP framework was accepted as an effective model for quality improvement and all stakeholders agreed that this model would be adopted for use by the CMOs. The BCAP model was implemented at each CMO during 2003.

Family Care Quality Framework

The Centers for Medicare & Medicaid Services (CMS) engaged the services of several national entities to facilitate the development of a Home and Community-Based Services (HCBS) Quality Framework, to serve as a uniform format to describe the key components of a state's quality assurance and quality improvement programs. The framework focuses on the desired outcomes of quality management and improvement efforts and identifies seven broad quality domains or focus areas:

- ***Participant access*** – Individuals have ready access to home and community-based services and supports in their community;
- ***Participant outcomes and satisfaction*** – Participants are satisfied with their services and achieve desired outcomes;
- ***Participant safeguards*** – Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices;
- ***Provider capacity and capabilities*** – There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants;
- ***Participant rights and responsibilities*** – Participants receive support to exercise their rights and in accepting personal responsibilities;
- ***Participant-centered service planning and delivery*** – Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community; and
- ***System performance*** – The system supports participants efficiently and effectively and constantly strives to improve quality.

Utilizing the HCBS Quality Framework as a guide, this report provides a summary of the 2003 EQR findings across the five CMOs and nine resource centers.

EQRO Findings for 2003

Domain: Participant Outcomes and Satisfaction

“Participants are satisfied with their services and achieve their desired outcomes.”

Participant Outcomes and Satisfaction: 2003 EQR Findings

Member Outcome Interviews

One of the 14 Family Care outcomes is that people are satisfied with their services. MetaStar began conducting member outcome interviews for Family Care members in 2003. During the 2003 member outcome interviews, questions were asked of members to obtain information regarding their expectations and needs for services and supports, and to assess whether services and supports were provided that met the member’s expectations and needs. The table below shows the 2003 findings from member outcome interviews related to members’ satisfaction with their services:

People are Satisfied with Their Services – 2003 Aggregate Findings

<i>Family Care Outcome</i>	<i>Outcomes Met</i>	<i>Supports Present</i>
People are satisfied with their services.	71.28%	71.08%

Outcomes related to satisfaction with services ranged from 69.27 percent to 75.0 percent for individual CMOs, and supports were present from 60.49 percent of the time to 85.71 percent of the time.

Quality Site Reviews

Member feedback allows members the ability to participate in CMO quality improvement and provide input on the quality of the CMO services. Obtaining member feedback allows the CMO to identify successes, potential problems and barriers to care and to provide potential members with information they need to choose a CMO. During the 2003 quality site reviews, CMOs were asked to describe the systems and processes they have in place to measure member satisfaction on a regular basis.

Most CMOs have not sought member feedback formally. Portage County CMO is the only CMO to have conducted a formal member satisfaction survey. They enlisted the assistance of their local Long-Term Care Council to conduct member surveys. Analysis of the survey results identified some areas of low member satisfaction, which will be used for quality planning. They also plan to conduct a follow-up survey in 2004.

MCAP Reviews

During the third quarter of 2003, the criterion listed below was added to the MCAP review in an effort to measure the extent to which CMOs identify and use member-defined outcomes during the assessment and planning process.

2003 MCAP Criteria Related to Participant Outcomes

<i>Criteria</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
Identifying member-centered outcomes that were defined by the member.	92	100	96	87	94	92

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

All CMOs are incorporating member outcomes into their planning process to some degree. A common approach currently being used in the care plan development is to address the most important one or two outcome areas defined by the member. While it is important to focus on issues that are most important to members, this method could result in having several other areas of importance to the member go unaddressed, which may need to be addressed in order to achieve the member's priority outcomes. For example, a member may prioritize his/her outcome for "staying in my own home" and "feeling safe in my neighborhood" as their two most important outcomes. However, to achieve these two priority outcomes, other additional areas of the member's life (outcome areas) may first need to be present, such as health or connections to informal supports.

The Fond du Lac CMO has developed a format for care planning that prompts care managers to address all 14 Family Care outcome areas. The outcomes that are already present or that are not important or relevant to the member are noted as such on the member-centered plan and are then triggered for periodic review. For outcomes that are identified as priority outcomes or outcomes necessary to help achieve priority outcomes, further information is documented regarding the services and supports required to achieve these outcomes.

Participant Outcomes and Satisfaction: Summary and Recommendations from 2003 EQR Findings

Results from member outcome interviews showed that approximately 29 percent of the members that were interviewed did not achieve satisfaction with their services or that supports were not in place to help members achieve satisfaction with their services. The CMOs' contract with DHFS require each CMO to seek formal member input, through member surveys, face-to-face interviews, or other means (Sect. VI; B:76); however, only one CMO has attempted to obtain formal member feedback. Satisfaction feedback from members would enable the CMO to determine gaps in services, improve existing services, and identify areas for expanding the provider network. Information obtained from formal member feedback could be used for quality improvement planning, which could in turn, may lead to increased member satisfaction and the achievement of members' desired outcomes. MetaStar recommends that each CMO develop and implement a formal process for obtaining and analyzing member feedback on a regular basis.

CMOs have begun and should continue, to use member outcomes as the cornerstone of member-centered planning. To further support using an outcomes-based model, MetaStar recommends that member outcome training be provided to all new CMO staff during orientation and that interdisciplinary teams continue to receive on-going member outcomes training on an annual basis. MetaStar also recommends that DHFS and CMO representatives form a workgroup or use an existing workgroup, to develop guidelines for assessing and including member outcomes in care planning, using Fond du Lac County's care planning format as a "best practice" model.

Domain: Participant Access

“Individuals have ready access to home and community-based services and supports in their community.”

Participant Access: 2003 EQR Findings

Resource Center Quality Activities

The following consumer comments illustrate how a Family Care resource center provides services to many citizens, including many who do not enroll in Family Care.

A consumer included this note when returning the consumer survey to the Portage County Resource Center:

“Last October my 92 year old mother had been badly bruised and shaken as a result of having been in an auto accident. Luckily there were no broken bones, but she was in terrible pain and had lost her mobility—she couldn’t get in and out of bed—she couldn’t walk. Prior to the accident she had been relatively self-sufficient. My son and I were not prepared emotionally, or in any other way, to deal with her sudden disability.

My family is new to the Stevens Point area. We only moved here in August of 2003. When I saw your public service announcements on television, I jotted down your phone number not realizing then that I was soon to need your services. I wish I had the name of the woman I spoke with that day in October, for she not only cheerfully gave me the “information” I requested, but she gave me the “peace of mind” I so desperately needed. I cannot tell you what a comfort it was for me and my family to know that there was help out there.

Thanks to you we were able to get my mother a wheelchair, and connect with Point Plus to transport my wheelchair bound mother back and forth to her weekly appointment at [the hospital].”

Information & Assistance; Options Counseling

Resource centers are in the business of providing information. As the point of access for long-term care in Family Care counties, resource centers are under contract to provide information and assistance (I&A) to a wide variety of consumers. In 2003, Family Care resource centers responded to over 61,000 inquiries from consumers, a decrease from 2002. A decrease of nearly 10 percent should be monitored by the Department, as it might indicate a change in the marketing by the resource centers or other changes. According to DHFS’ 2003 quarterly activity reports, the majority of inquiries are about basic needs and financial services, disability and long-term care services, or living arrangements. These three topics consistently comprise nearly 55 percent of all inquiries to resource centers year after year.

In their capacity as the point of access for information, resource centers need to provide information that is both accurate and up-to-date. It is challenging to stay up-to-date with a field that is growing and changing as constantly as the long-term care industry.

Resource centers address the need to stay current by routinely inviting long-term care providers to staff meetings. Staff may be assigned to geographic areas of their county or to specific programs or services, with the responsibility to stay current in those areas and share new information with the rest of the staff. A few resource centers have full-time staff to manage their information. However, it is more common that gathering and updating information is a shared responsibility among staff, and only one of many responsibilities.

Websites are becoming more common for Family Care resource centers. Two years ago few resource centers made information available on a website. Those resource centers that had a website had passive sites. They presented information, but did not have the capability to receive questions and transmit information back to on-line consumers. Therefore, few consumers contacted the resource centers via websites. Most of the resource centers now have websites and find that they are getting more use. Two resource centers (Kenosha and La Crosse) are adding their resource directory to their website. However, most resource centers cannot track how many hits they have to their web site, and I&A current reporting methods does not distinguish the source of the contact. Contacts via website are distinguished from any other method of inquiry.

Counseling about long-term care options is an extended form of I&A, requiring more time with consumers than a routine phone inquiry. Usually, options counseling occurs at a consumer's home and often it includes conducting the Long-Term Care Functional Screen, since this provides useful information about the person's needs. Options counseling can lead to enrollment in Family Care, referral to privately-funded long-term care services, or in counties without the Family Care benefit, to referral to Community Options Program (COP) and the waivers available in that county. Options counseling allows resource center staff time to explore with a consumer or a consumer's family more of their personal circumstances, and offers the opportunity to individualize the information provided to consumers.

A strong program for options counseling has the same requirements as a quality I&A program. Both require staff who are skilled communicators and knowledgeable about community resources. Both programs require printed information to be available in the primary languages of the county and in type styles or alternative formats for persons in need of these alternatives. Resource centers also vary in the amount of time they report in options counseling. Some report that it takes several visits to gain the trust of a consumer and to adequately complete options counseling. On the other hand, Milwaukee limits options counseling to one home visit.

In 2003, the resource center site visit review team participated in home visits to conduct options counseling in seven counties with 18 consumers. It was the first observation by DHFS and MetaStar staff of options counseling in action. Following most sessions the review team asked consumers to complete and return a short survey. MetaStar received 10 of the 18 surveys (56 percent return rate). A summary of consumers' responses is available in Appendix B. Consumer feedback was favorable. This was preliminary information based on a small, unrepresentative sample. However, it is the first data available that indicates how consumers respond to options counseling offered by resource centers.

Resource centers are not providers of long-term care services, but refer consumers to other public or private agencies that can serve the consumer. Resource center staff do not recommend services. Instead they provide unbiased and up-to-date information that assists consumers to make informed decisions.

Resource centers provide two direct services to consumers -- short-term care management and the Disability Benefits Specialist program. Resource centers establish their own guidelines for MetaStar, Inc.

short-term case management, and they determine criteria for case management and the length of time a consumer receives this service. Reporting of time spent on these activities has been inconsistent. For example, Fond du Lac County does not report any hours in this category. The Disability Benefits Specialist program is housed at the resource centers. The Bureau on Aging and Long-Term Care Resources provides program oversight and contracts for legal backup. The Benefit Specialist serves younger people with disabilities (those under 60) and is a worthwhile addition to the resource center. Due to the high demand, many resource centers have funded additional hours for this program.

Organizational Processes

By contract, resource centers must be accessible to all consumers. They have implemented this requirement in the following ways:

- Physical facilities are wheelchair accessible;
- 800 numbers;
- TTY technology for consumers with hearing impairments;
- For persons whose primary language is not English, some resource centers have hired bilingual staff fluent in the languages of their county. Others contract with interpreters and those that have fewer occurrences contract for phone translation;
- Printed materials in different languages, large print, and braille;
- Resource center staff are available during extended hours; and
- Phone answering service that is available 24 hours, 7 days a week.

These practices help to make resource centers user-friendly, as well as accessible to consumers. Most resource centers are located in the main county human services building. Many of these locations are visible and adequately meet the needs of the resource center operation and support staff meeting with consumers in their offices. However, the location of the resource center in Richland County is less than ideal with the coroner's office located in the same hallway. In Fond du Lac County the I&A staff are conveniently located off the main entry of the human services building. However, the space is small and does not accommodate meetings with consumers, who often need to be escorted through locked doors to the basement staff offices. In Milwaukee consumers must check in with a security guard and then be escorted to the resource center. The Milwaukee resource center is addressing this issue by placing some I&A staff in senior centers. Other resource centers offer spacious quarters in senior centers that are inviting to older consumers (Portage, Marathon), but have little to appeal to other target groups. More needs to be done to make resource centers' physical space attractive to all target groups and more easily accessible to consumers.

Resource centers raise public awareness through marketing and outreach. Much of the outreach has been cost-effective. For example, resource centers developed brochures and directories and distributed practical give-away items such as magnets, pens, pill boxes, and jar grippers with the name and phone number of the resource center. These items are distributed at large community gatherings, such as health fairs, meal sites, wellness clinics, and to consumers when staff makes home visits. Resource center outreach strategies also include writing articles for local newspapers or community service papers and appearing on call-in radio or local access television shows. The Richland County Resource Center printed and distributed placemats to area restaurants, providing high exposure for the resource center. Some resource centers have ventured beyond these more traditional marketing methods. La Crosse and Trempealeau counties joined together to make a television ad and Portage and Richland have aired radio advertising. There is no evidence to support the effectiveness of media marketing compared to other methods. This is an area that requires more analysis.

Much of the resource centers' outreach appeals to older adults, e.g., presentations at meal sites, screenings at wellness clinics, and health fairs and the giveaway items. Resource centers are attempting to broaden their outreach. Among the newest ideas was the appearance by Portage County Resource Center staff at corporate Employee Assistance Programs (EAPs) fair.

An important aspect of public awareness and outreach is relationship building. Resource center staff and managers continue to meet and exchange information with staff at long-term care facilities, housing units, and service agencies serving their target populations, including staff from other county agencies. Relationship building helps all aspects of resource center communication, but it is particularly helpful with the Pre-Admission Consultations (PAC) process required of a consumer moving into long-term care facilities such as a nursing home, adult family home, community-based residential facility, or residential care apartment complex.

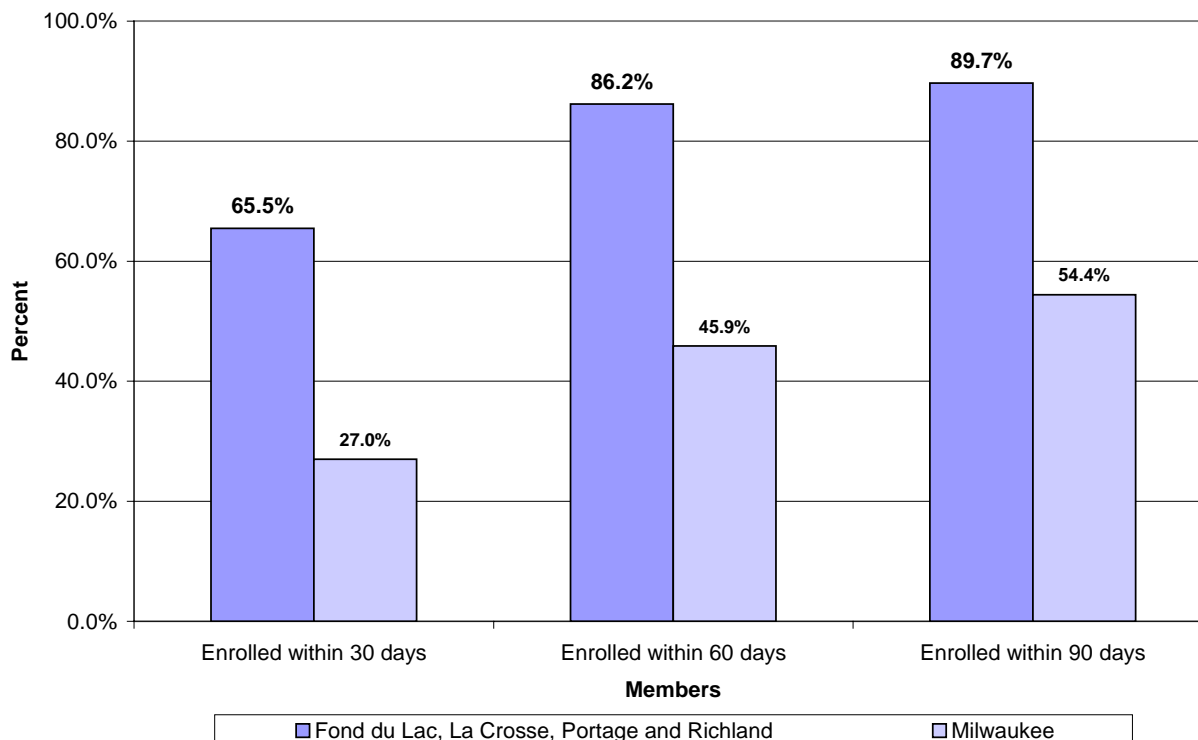
All of these efforts – items to give away, media marketing, and relationship building – publicize the services and availability of resource centers and continue to keep the resource centers in the public's eye.

Enrollment and Eligibility Determination

Resource centers are responsible for enrolling consumers in the Family Care program. Enrollment starts with I&A and options counseling, including functional eligibility determination through the Long-Term Care Functional Screen (LTC FS). Resource center staff are the axis of the enrollment process, facilitating each consumer's movement through the enrollment process – to the Economic Support Unit to complete their financial eligibility, to the Independent Enrollment Consultant to ensure that the consumer wishes to enroll, and ensuring that process reaches the CMO to complete the enrollment. In 2003, 2524 consumers were enrolled in a CMO and experienced this enrollment process.

Timeliness is an important factor in the enrollment process. A study was commissioned by DHFS and completed by MetaStar in 2003. The study analyzed a sample of enrollments that occurred between August 2002 and the end of February 2003. Of the 1,500 enrollments, 150 were analyzed. The study relied on data available at DHFS, including the Long-Term Care Functional Screen, the CARES system, (Client Assistance Re-employment and Economic Support system), the enrollment consultants' database, and enrollment dates from MMIS (Medicaid Management Information System). The performance standard in the resource center contract states that the enrollment must be established and entered in CARES no later than 30 days after the "application date", generally understood to be when a Medicaid application is received by the county eligibility agency. Because this study relied on administrative data available at the state and not resource center records, it used the date functional eligibility was calculated on the LTCFS as the proxy for the start of the enrollment process. The results of this study were shared with the resource centers. They were asked to review the circumstances that caused some enrollments to be delayed. These results were reported during the 2004 site visits.

Family Care Enrollments Research Results



The information available for this study allowed the reviewer to examine the role of the independent enrollment consultants and to determine if the enrollment consultation was in any way responsible for lengthening the process. In the four counties (Fond du Lac, La Crosse, Portage, and Richland), 69.5 percent (range 64.3 - 88.9 percent) of enrollment consultations occurred on the same day the referral was received. A total of 91.5 percent of all referrals were completed within four days of the referral and only 3.4 percent were not yet completed after seven days following the referral. In Milwaukee County, 49.5 percent of enrollment consultations occurred on the same day as the referral; 81.4 percent were complete within four days of the referral; and 3.3 percent were not yet completed after seven days following the referral. These data suggest that the enrollment consultation process is not causing delays in the enrollment process.

Long Term Care Functional Screen

Integral to the resource center's role in enrollment is the administration of the Long-Term Care Functional Screen (LTC FS). The LTC FS is the tool that determines functional eligibility for the Family Care benefit. Resource center staff administer all initial screens. Over 5,200 initial screens were completed in 2003, but this does not account for all of the screens completed in 2003. There are two other types of screens conducted for Family Care members – change of condition screens and annual re-certification screens. These types of screens may or may not be completed by the resource center. In Fond du Lac, Milwaukee and Richland counties, CMO staff are responsible for the latter two types of screens. In 2003, the number of annual re-certification screens – 7,303 – surpassed the number of initial screens. Portage and La Crosse resource centers maintain the responsibility for all screen activity.

Assurances that the LTC FS is administered reliably are addressed through contract and DHFS requirements. All screeners must meet a minimum level of education and years of professional

experience working with consumers in a Family Care target group. Also, every screener must pass a web-based training course before gaining access to the LTC FS.

Every Family Care screening agency is required to develop and implement LTC FS policies and procedures and an annual quality improvement plan. These are then submitted for review annually to DHFS and MetaStar.

Since 2002, DHFS has required a form of inter-rater reliability testing (IRRT) to help assure quality of LTC FS administration by resource centers. Within a specified period of time, all screeners in a local agency complete a screen using a written description of an individual. CMOs were required by contract to administer the IRRT to screener staff for the first time in 2003. A total of 323 Family Care screeners from 34 agencies took the IRRT in 2003—nearly double the number who took the IRRT in 2002 in 2003. As this was the first year of testing Milwaukee CMO screeners, only a sample of their screeners participated in IRRT and their scores were excluded from the all-agency scores, the basis of overall comparison. The 2003 all-agency results by domain are available in Appendix C.

Individual and agency IRRT results are distributed to each agency, along with the overall scores. Any screener with a score below 70 percent in any domain (ADLs, IADLs, Health Related Services, Communication/Cognition, Behavior/Mental Health, and Risk) is required to have an individual plan to provide special training and mentoring. All agencies are encouraged to use the results of the IRRT for general LTC FS training.

A second screen analysis, a screen discrepancy study, was completed in 2003. During member-centered plan reviews of a sample of new members, their functional screens were compared to the CMOs' health and physical assessments, and the results were analyzed by MetaStar staff. Through an extensive review of each LTC FS domain, the reviewer examined every instance where the initial screen differed from the CMO's assessment. The purpose of this review was not to identify where the "error" was, but rather to highlight the differences between two evaluations of the same person completed within a short time period of time. There were 53 new member screens and assessments reviewed for this study. The review period covered the last quarter of 2002 and the first and second quarters of 2003. Most discrepancies were found in Activities of Daily Livings (ADLs). Health Related Services were second; Instrumental Activities of Daily Living (IADLs) were third; and "Diagnoses" was fourth. All other domains had considerably fewer discrepancies than these top four areas. This study, along with the results of the 2003 IRRT confirms that there is opportunity for improvement in the administration of the Long-Term Care Functional Screen.

Disenrollment

Voluntary disenrollments from a Family Care CMO are handled by the resource center. The resource center is contacted when a member indicates that s/he is considering disenrollment. The resource center, considered an impartial agency, is able to provide options counseling and accurate information for the member to consider when making a decision about disenrollment.

In 2003, DHFS expressed interest in learning more about disenrollments, including the reasons why CMO members choose to disenroll. MetaStar was asked to conduct a study of reasons for disenrollment in 2003. Three sources of information were used for the study; the statistical summary of disenrollments by category from the resource center quarterly reports, information drawn from copies of the disenrollment forms received by DHFS, and information from a disenrollment study conducted by the Fond du Lac County Resource Center on disenrollments.

The first step in the study was to request more consistent reporting on the resource centers' quarterly narrative reports, the primary source of information collected from the resource centers on their disenrollment activity. The new format began with the second quarter's report. The information from the quarterly reports allowed the reviewer to develop categories of consumers' reasons for disenrollment and the complete number of disenrollments for the year. Because not all resource centers used the new format consistently, the information provided for 2003 from the resource centers' quarterly narrative reports couldn't be used confidently in analyzing disenrollments or members' reasons for disenrolling.

The core of the review was the information gathered from the disenrollment forms received from Electronic Data Services (EDS), DHFS' fiscal agent and manager of the data warehouse. The disenrollment form provides basic demographic information, the member's social security number, date of disenrollment, and often more detail about the member's reason for disenrolling. This information allowed the reviewer to use the CARES system and the LTC FS to gather more information. From CARES, the reviewer found information on where consumers moved when they moved out of the service area, date of death, when applicable, date of re-enrollment in the CMO, and prior disenrollments. While this information could not be considered complete or consistent, it did assist the reviewer and added more information to the disenrollment study. The target group and level of care were available from the LTC FS.

The most common reason (40 percent) for disenrollment was a move out of the service area, which results in loss of eligibility for the program. A distant second reason was the desire to enroll in Medicaid fee-for-service, usually for, nursing home care. This study showed that most members did not disenroll shortly after enrolling, as initially thought. The highest percentages of disenrollments (18 percent) that occurred within the first 30 days were in Milwaukee and Fond du Lac counties. The largest portion of disenrollments (38.8 percent) occurred after a year's membership in a CMO. This likely relates to the primary reason for disenrollments - moving out of the service area. In addition to the reasons for disenrolling, the study also revealed that nearly 8 percent of members re-enrolled in a CMO after disenrollment and that a significant number of members (6.6 percent) died shortly after disenrolling. The source of death reporting was the CARES system; however, the information was not always present, as it was not required in the system.

Summary

After four years of operation, all resource centers continue to work on maintaining accurate information. Resource centers have developed systems to update the vital information for consumers. Resource centers continually update printed information, including brochures, which are sent in or presented to consumers as they consider their LTC choices.

Most resource centers appear to be well known in their counties, although this varies from county to county. Using a variety of methods, resource centers have worked to maintain public awareness of their services.

The goal of the resource center serving as the single entry for the LTC information and assistance has not been fully realized. Most counties continue to maintain other resources, such as their aging unit, that serve the same population as the resource center. Rather than referring consumers to the resource centers they "compete," perpetuating a confusing and disjointed system to consumers seeking LTC information.

Although enrollment often takes more than 30 days according to the study conducted in 2003 and the marker events used in that study, the four non-Milwaukee Resource Centers have timely and accountable systems for enrolling consumers into a CMO and appear to maintain good working relationships and communications with the local Economic Support Unit and CMO.

Appeals and Grievances

Appeals related to eligibility go right to the state fair hearing process and MetaStar does not generally investigate these cases. However, MetaStar does input these appeals into DHFS' database, and provides data regarding these appeals to DHFS.

During 2003, there were 63 appeals and/or grievances related to eligibility across all CMOs. Of these 52 were from frail elderly members. All of the eligibility-related issues were in Milwaukee County, with the exception of one that was from La Crosse County. It appeared that the large number from Milwaukee County was due to a policy that was temporarily implemented by the CMO, where care managers were instructed to recommend filing a fair hearing request whenever there was any delay in annual eligibility recertification, without regard to whether the matter could be resolved internally with no loss of eligibility for the member.

Whereas the DHFS process typically does not get involved in eligibility-related issues, the situation in Milwaukee in 2003 was unique to the above noted policy they had implemented. This issue was referred to DHFS for further follow-up.

Participant Access: Summary and Recommendations from 2003 EQR Activities

Most resource centers are making incremental changes to their administrative processes. While these changes are important to the smooth operation of the resource centers, many have misinterpreted administrative change for quality improvement. For the most part the changes made by the resource center have not followed any model of quality improvement and none are based on data measured over time, a principle of quality improvement. The resource centers require additional training and assistance in the area of quality improvement processes and techniques.

Most resource centers appear to have timely and accountable systems for enrollment; however, improvement is needed in timeliness of eligibility determination and enrollment in Milwaukee County.

The results of two years of inter-rater reliability testing reveals that many screeners are not improving their screening skills, as evidenced by this test. In two of the six domains of the screen, results declined between 2002 and 2003. Opportunities exist to improve the training and testing of screeners.

Resource centers are reaching out to their communities and consumers. Monitoring the effectiveness of their various marketing techniques would assist the resource center in focusing their resources on their most successful techniques.

Websites are an increasingly popular method of getting information for consumers. Only a few resource centers are now able to track the number of hits on their website. This feature should be incorporated into all resource center websites. Without being able to track the number of consumers who use this method of inquiry, the contact numbers will not reflect the actual number of contacts made by consumers. The Department should review the I&A statistical reports and make changes to reflect the changing nature of the resource center's contacts.

Options counseling is an area that requires further analysis. The small study conducted by the review team in 2003 only slightly opened the door to this activity. It is recommended that DHFS follow-up on the initial study of options counseling conducted in 2003 with a more extensive study. This could include developing guidelines and providing additional staff training.

Further follow-up on the disenrollment study data needs to occur. The study provided information that could be used to set a baseline for comparison and more could be learned about disenrollments through follow-up studies.

Domain: Participant Safeguards

“Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.”

Participant Safeguards: 2003 EQR Findings

Member Outcome Interviews

During the 2003 Member Outcome Interviews, three of the 14 Family Care outcomes related to participant safeguards. One outcome was that people are safe. To determine if this outcome was met or if supports were in place that helped members achieve this outcome, interviewers asked questions that elicited information about whether members lived, worked, and pursued leisure activities in environments that they felt were safe. Interviewers also gathered information about whether members knew how to respond in emergency situations, such as if a fire occurred in the living environment. Support questions focused on whether the CMO had identified safety issues for the member or if the member was provided with the necessary supports to address any safety issues.

The second outcome related to participant safeguards is that people have the best possible health. To determine if this outcome was met or if supports were in place that helped members achieve this outcome, interviewers asked questions to determine whether members were seeing health care professionals, whether health care professionals had identified the member's current health situation while addressing health care issues and concerns, whether interventions and services were selected by the person in consultation with their health care professionals, and whether health care interventions and services were effective. Support questions also identified whether the IDT knew what the person's definition of “best possible health” was, whether supports were provided for the member that promoted their health, whether the CMO responded to the person's changing health needs and preferences, and whether individualized supports were in place to support their health outcomes.

The third outcome related to participant safeguards is that people are free from abuse and neglect. To determine if this outcome was met for members or if supports were in place that helped members achieve this outcome, interviewers asked questions about members' history of abuse and/or neglect. They also asked questions to determine if there was any evidence of past or present abuse and/or neglect or if the person was experiencing any personal distress related to a previous experience of abuse or neglect. Support questions assessed whether the CMO knew about the person's concerns (if any) regarding abuse and/or neglect, whether the CMO provided the person with information and education about abuse and neglect, and whether the CMO provided support for members when they expressed concerns about past or present occurrences of abuse or neglect.

The table below shows the 2003 findings from the member outcome interviews related to participant safeguards:

Outcomes Related to Participant Safeguards – 2003 Aggregate Findings

<i>Family Care Outcome</i>	<i>Outcomes Met</i>	<i>Supports Present</i>
People are safe.	70.47%	67.21%
People have the best possible health.	55.40%	61.71%
People are free from abuse and neglect.	86.15%	74.13%

Health and Safety Concern Protocol

Member outcome interviews sought to ensure participant safeguards by utilizing a health and safety protocol during the member outcome interview process. During each member outcome interview, if the interviewer determined that a health or safety concern was present, a protocol was applied that consisted of a referral of the issue to DHFS. Further follow-up was then conducted by MetaStar, The Council, and/or DHFS until the concern or issue was resolved. During the 2003 interview cycle, there were seven health and safety concerns spanning various issues that were identified and referred to DHFS for follow-up.

In 2003, DHFS, in collaboration with the CMOs and The Council held discussions about certain “foundations” or “basic assurances” that are necessary to ensure the health and safety of Family Care members. One of the “foundational” outcomes identified was the outcome related to “best possible health”. The outcome related to “best possible health” had the lowest results for both outcomes met and supports present. During discussions with IDT members following the member outcome interviews, the care managers expressed that they were unclear regarding their role in supporting members to achieve their health-related outcomes. There was also uncertainty among the IDTs on when to follow-up with members who have refused to participate in managing their health care needs.

Quality Site Reviews

While the Family Care program does not encompass primary health care services, maintaining or improving a member’s health is beneficial to improving the overall quality of long-term care and is one of the goals in Family Care. To accomplish this, the CMO provides members with information about services and resources to meet their needs and outcomes, how they can contribute to the maintenance of their own health, and the appropriate use of long-term care and health care services. According to the contract between DHFS and each CMO, safety and risk policies need to be approved by DHFS and implemented by each CMO (Sect. III; D:38). The quality site review determines whether CMOs have developed and implemented policies and procedures to ensure members are safe in all aspects of their lives. To assist in determining this, the following were some of the questions asked during the on-site visit:

- Share with us processes/procedures the CMO has put in place to promote the effective use of primary care, specialty care, and emergency services.
- Discuss a meaningful time when the IDT assisted a member to receive necessary medical attention by coordinating primary health care services.
- Discuss a time when the IDT successfully addressed a member’s choice and/or refusal of services that created risks associated with the member’s decision.
- Discuss how the CMO effectively monitors, evaluated, and improves its performance in the area of member safety and risk.

The Fond du Lac CMO stated that its Provider Network Developer trains providers on critical incident reporting requirements, abuse and neglect issues, and reporting requirements for the use of restraints and seclusion. In addition, it’s Member Safety and Risk policy requires that a provider can not institute restraints and seclusion until there has been a referral to and an evaluation by a behavioral specialist.

The Portage CMO has implemented a risk assessment protocol which assists IDTs in educating members on the consequences of their risk-taking behavior, and has successfully developed negotiated risk agreements with the member when appropriate.

The La Crosse CMO described a medication management consulting service they arranged with several area pharmacies. The care management teams are able to refer members for consultation needs, such as bubble packing medications, which supports medication management by the member.

The Milwaukee CMO plans to hold an annual in-service for area hospital discharge planners to overcome the challenge of coordinating services for members who are discharged from a hospital setting.

The Richland CMO was in the process of creating a restraint policy as part of their greater policy for rights, restraints and seclusion.

To assure that IDTs play an active role in health promotion and prevention for members with mental health concerns and durable medical equipment needs, La Crosse County CMO has contracted with a psychologist and a psychiatrist as consultants to IDTs and with skilled therapists to complete home safety evaluations.

In 2002, CMOs had not implemented member safety and risk policies. In 2003, it was noted that CMOs established and implemented member safety and risk policies to address members' rights to be free of unnecessary physical or chemical restraints. CMOs also have mechanisms in place to facilitate safe environments for members, while taking into account individual choices related to risk taking behavior. Teams provided several examples of how they were able to work respectfully with members at their own speed to effect needed changes in health behaviors.

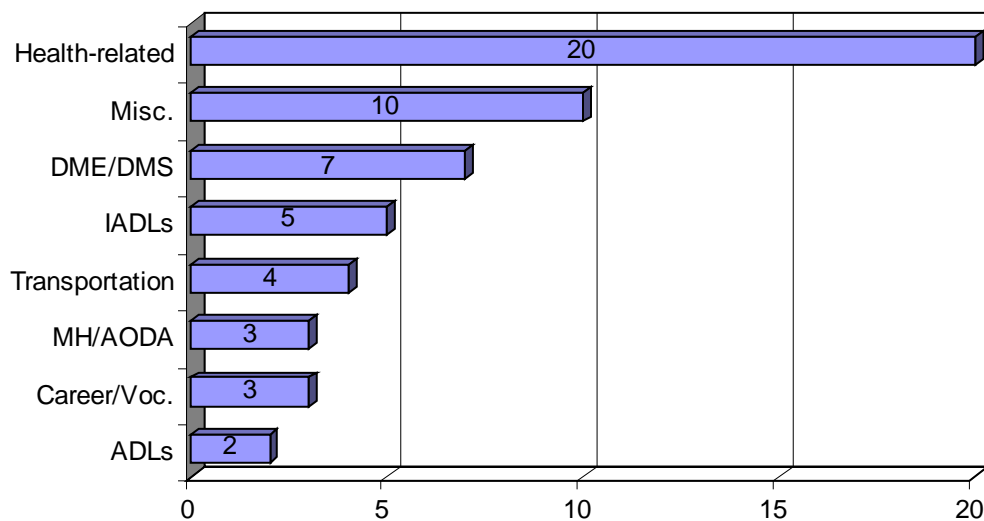
MCAP Reviews

The MCAP review process is a concurrent review. During the 1st level of review, unmet needs and/or health or safety concerns may be identified. If so, the CMO is asked to provide additional information that addresses the issue or concern. If the additional information provided does not adequately address the concern or if the CMO does not have any additional information, then they must complete a corrective action plan that addresses any unmet and/or any current health or safety issues. Plan reviews are not approved until all identified unmet needs and/or health or safety concerns have been adequately addressed by the CMO.

The tables below show a distribution of all potential unmet needs and health or safety concerns that were identified during the initial review process for 2003.

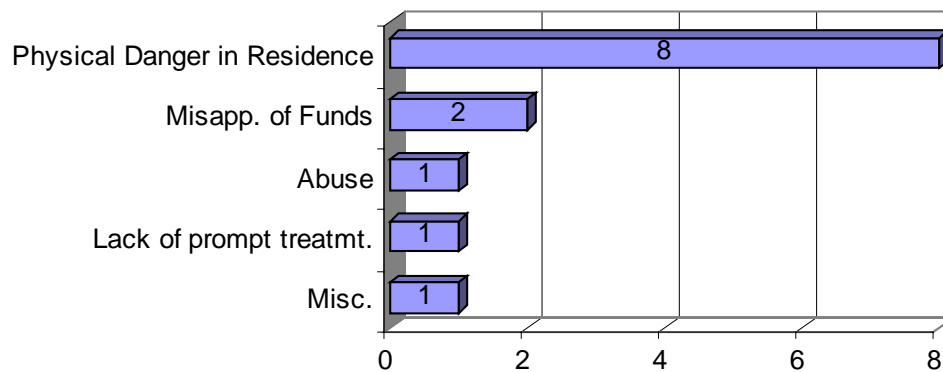
Unmet Needs by Category

All CMOs 2003



Health/Safety Concerns by Category

All CMOs 2003



Of the 404 plans reviewed in 2003, there were a total of 54 unmet needs and 13 health or safety concerns identified during initial review. It appears that the largest category of unmet needs was health-related and the largest category of health and safety issues was related to physical dangers in the residence. In most instances, The CMOs provided additional information that adequately addressed these issues and concerns. In two instances, corrective action was required and completed. For 2003, all concerns regarding unmet needs and/or health or safety concerns were resolved at or before the third level of review.

Another way that the MCAP review evaluates the safety of members is by assessing the CMOs' efforts in identifying and addressing risk with members.

Of note, approximately 37 percent of unmet needs identified during initial reviews were health-related needs. Also, approximately 61 percent of the health or safety concerns identified during initial review were related to physical dangers in the residence.

The table below lists individual and aggregate findings for the above criteria related to risk for 2003.

2003 MCAP Criteria Related to Risk

<i>Criterion</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
When services were refused, the reason for the refusal was documented and the risks associated with the refusal were addressed with the member.	99	100	100	96	95	98

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

Unexpected Death Review

When an unexpected death occurs, each CMO completes a two-part standard form. Part one includes general member information and the circumstances surrounding the death. Part two includes analysis of potentially unsafe situations, causes/contributing factors, and actions/recommendations that are planned to prevent future occurrences. This is an opportunity for the CMO to ensure the safety and welfare of its members. The table below shows a summary of the causes of unexpected deaths reported in 2003:

Cause of Unexpected Deaths Reported in 2003

<i>Cause of Death</i>	<i># of Unexpected Deaths Reported</i>						<i>Issues Found</i>
	<i>Fond du Lac</i>	<i>La Crosse</i>	<i>Milwaukee</i>	<i>Portage</i>	<i>Richland</i>	<i>Total</i>	
Abuse	0	0	0	0	0	0	0
Falls	0	0	1	0	0	1	0
Homicide	0	0	0	0	0	0	0
Natural Causes	3	2	33	3	5	46	0
Suicide	1	1	0	0	0	2	1
Trauma	0	0	1	0	0	1	0
Vehicle	0	0	0	0	0	0	0
Other	3	1	5	1	1	11	0
Pending	0	0	0	0	2	2	0
TOTAL	7	4	40	4	8	63	1

During 2003, CMOs requested clarification on the definition of “reportable unexpected deaths”. Based on this request, it was felt that CMOs may have been over-reporting and/or under-reporting unexpected deaths. In response to this request, the DHFS and MetaStar developed and implemented a policy and procedure for reporting unexpected deaths, which included specific definitions for unexpected deaths (Sec. III; D:38).

There were two unexpected deaths as a result of suicide in 2003. In response to the suicide in La Crosse, the La Crosse CMO began developing policies and protocols on suicide prevention.

Participant Safeguards: Summary and Recommendations from 2003 EQR Findings

In 2002, CMOs were continuing to define the role and expectations of the RN in Family Care. In 2003, the outcome for “best possible health” was present for only 55.4 percent of the members interviewed, and supports for promoting members to achieve this outcome were present for only 61.7 percent of the members interviewed. These findings could likely be improved if the CMOs

further defined and articulated the role of the RN within the Family Care model. Defining this role should be a priority. A well-defined RN role should include providing clear expectations for IDTs regarding health promotion and prevention interventions, along with clear expectations of the level of involvement the RN should have in assessing and monitoring members' health-related issues. MetaStar recommends that the CMOs and DHFS collaborate to define a case-management model appropriate for Family Care RNs, along with specific expectations for Family Care RNs within that model. MetaStar also recommends that once a case management model and expectations have been agreed on by all stakeholders, training should be provided for all CMO RNs and Social Workers.

In 2002, CMOs had not yet implemented member safety and risk policies. In 2003, CMOs had implemented safety and risk policies; however, the outcome for safety was present for only 70.4 percent of the members interviewed, and supports were present for only 62.7 percent of those members. The majority of health and safety issues were related to physical dangers in the residence, while suicide and falls contributed to at least three unexpected deaths. It is likely that these findings could be improved if interdisciplinary team members receive ongoing education and support for working with members whose life choices may affect their health and safety, and training and support regarding member choice, risk identification and risk reduction. MetaStar recommends that all new CMO staff receive training in risk identification/reduction and negotiation skills during their orientation, along with annual training for all staff in these areas. MetaStar also recommends that each CMO identify and develop a list of local area expert resources that interdisciplinary team members can consult with when working with members whose choices place them at greater risk.

MetaStar is also recommending that each CMO develop suicide prevention guidelines that incorporate early warning signs, resources that can be drawn upon when working with suicidal individuals, and identification of risk factors associated with suicide. The La Crosse CMO is encouraged to share their knowledge and progress in this area with other CMOs.

MetaStar recommends that DHFS obtain further information about each CMO's reporting procedure for unexpected deaths during future quality site reviews.

Domain: Provider Capacity and Capabilities

“There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.”

Provider Capacity and Capabilities: 2003 EQR Findings

Quality Site Review

In 2002, the ability to deliver services in a timely manner, and the development and implementation of standards related to access to services was found to be lacking across all CMOs. Therefore, the 2003 Annual CMO Quality Site Review focused on the availability of services and the establishment of the provider network. During the CMOs’ annual re-certification and re-contracting process, DHFS assessed the capacity of each CMO’s provider network to ensure it anticipates future enrollment, identifies the number of network providers not accepting new Family Care members, projects the needs of the membership so that it maintains an adequate network capacity, determines if the CMO has established standards for travel and distance times to providers, and assesses the CMO’s capacity to offer services 24 hours per day, seven days per week. The following questions were also asked during the 2003 quality site reviews:

- Describe a time when a new provider was successfully added to the provider network.
- Describe any considerations the CMO has made when determining the current adequacy of the network and the future needs of the network as enrollment increases.
- Describe how the CMO supervisors/managers monitor for timely, geographic and physical access to services for members.
- Share an example of how a provider met or exceeded the CMO’s contract expectations (such as performance indicators).
- Describe a time when an out-of-network provider was used to support a member’s outcomes.

The Milwaukee CMO stated that their Contract Specialists proactively monitor the quality of providers by making periodic on-site visits to observe the care and services provided to members. They also identified that substitute care, housing capacity and choice within the county is in short supply. They plan to add staff to increase contacts with providers in an effort to increase their ability to respond to members’ needs and choices of community-based housing.

The Richland Provider Network Developer follows-up on concerns received from members or IDTs in Richland by documenting the concern, meeting with the provider and having the provider sign the written document of the concern. This allows them to focus their provider recruitment efforts.

In La Crosse, the contracted providers submit self-evaluations to the CMO on an annual basis. These include goals for the coming year. Written expectations may be included in future contracts.

Milwaukee and Fond du Lac CMOs have processes in place for the Provider Network Developer to relay provider concerns to all IDTs in a timely manner to assist with service authorizations.

In reviewing for geographic access to providers, Portage CMO has taken advantage of contracting with out-of-county providers for services needed by members who live near the county border. The Richland CMO planned on developing and implementing a process for monitoring access standards through geographical mapping of providers within the county.

IDTs have been persistent in seeking out difficult to find resources for out-of-benefit package services. The La Crosse CMO described their ability to access a “procurement credit card,” which allows IDTs to order needed items for members from out-of-network providers. The availability of the credit card enables IDTs to have a high degree of responsiveness to members and to support timeliness in meeting member outcomes. The Portage CMO shared examples of how they utilize out-of-network providers to flexibly meet member outcomes, such as increasing services to enable a member to maintain attendance at an out-of-county college, and adding health club memberships as an option for members. IDTs in Fond du Lac are able to offer a one-month trial of a support or service that is not currently in the provider network, in order to determine if the support or service would be beneficial to a member. Informal member and IDT feedback related to limited supportive employment options in La Crosse prompted the Provider Network Developer to do further analysis, which resulted in confirming the need for additional providers.

All CMOs maintain written contracts with in-network providers, which are reviewed and updated annually. The CMOs utilize services and information from the Bureau of Quality Assurance when reviewing provider licensing requirements.

The Milwaukee CMO and the Fond du Lac CMO still need to develop standards for timely provision of services and processes for determining the quality of the provider network. In addition, the Milwaukee CMO and the Portage CMO still need to develop quality standards for 2004 provider contracts. DHFS did add these requirements into each CMO’s re-contracting letter for 2004.

**Provider Capacity and Capabilities:
Summary and Recommendations from 2003 EQR Findings**

The ability to utilize out-of-network providers enables CMOs to flexibly meet member outcomes on an individual level. Often these providers become part of the network and members are able to benefit from their services. CMOs have found creative ways of helping members to achieve their outcomes by being flexible with out-of-network providers.

MetaStar recommends that each CMO analyze and trend utilization of services data, along with membership growth data. This would enable them to take a more proactive approach in expanding their provider networks to accommodate member needs.

MetaStar also recommends that the Milwaukee CMO and the Fond du Lac CMO develop standards for the timely provision of services and that the Milwaukee CMO and the Portage CMO develop quality standards for their provider contracts. The development of these standards will help ensure that the CMO has sufficient providers with the capability to provide quality services for its members.

Domain: Participant Rights and Responsibilities

“Participants receive support to exercise their rights and in accepting personal responsibility.”

The following story illustrates how the Family Care appeal and grievance process can help members to exercise their rights as a Family Care member:

A forty-two year old Family Care member submitted a grievance at the DHFS level regarding his “rights being violated”. This member was physically disabled and had multiple medical problems as well as several mental health diagnoses, which required medications. The member’s CMO interdisciplinary team (IDT) worked closely with him. In an effort to coordinate care, the team asked the member to sign a release so that they could have direct contact with his physician. The team felt as though they were not able to properly address issues, especially related to the member’s adherence with medications. At the time the member filed the grievance, he stated that he had not been taking his medications for several weeks. By his own admission, he knew that this was a problem for him, but he really didn’t understand why he had to take the medications he was prescribed. He also didn’t like the side effects of the medications. However, the member was not willing to have his CMO team address these issues with his doctor, and felt that their request to do so was inappropriately infringing on his rights as a Family Care member. The member felt that the team was asking him to sign a release so that they could “work around him” and manage his care without his input.

During the investigation/mediation process, all parties collaborated, including the CMO team, the member, and MetaStar, to reach a resolution that was acceptable to the member. The member understood that it was his right to refuse to sign a release, but that the responsibility he had was to communicate with his physician and his CMO team. A resolution was reached that was agreeable with both the CMO team and the member, that included the CMO RN making a visit with the member to his physician’s office to review her concerns with both the member and his physician. Once that was completed, a follow-up plan could be addressed. The member felt that this was a good solution to his feeling “out of control” and it made him feel more a part of the team. The RN also felt that it would provide the CMO with the information they needed to better coordinate care for the member. In summary, the member and his team were able to find a way to meet his outcomes in a manner that promoted his need to feel in control of his care, while respecting his individual rights.

Participant Rights and Responsibilities: 2003 EQR Findings

Member Outcome Interviews

Three of the 14 Family Care outcomes relate to member rights. One outcome is privacy for members. During the 2003 Member Outcome Interviews interviewers asked questions to determine if members were afforded time during the day for private activities and if they had privacy, in general. Questions were asked to see if members had somewhere to go to be alone or with friends, if privacy was provided when requested, and if members were satisfied with their level of privacy. To determine whether supports were present, questions were asked to find out

if case managers knew the member's preferences for privacy and if not, were they making an effort to learn about the member's preference in regards to privacy.

The second outcome is personal dignity and respect. Interviewers asked questions to determine how members were being treated by others. Information was obtained on whether, from the member's perspective, they were being treated respectfully, and if interactions with others demonstrated concern for their opinions, feelings and preferences. Support questions elicited information about whether case managers knew what was important to members regarding respect, and whether supports were in place to enhance the member's self-image.

The third outcome is that people are treated fairly. Interviewers asked questions regarding member rights and fair treatment. If there were any reported limitations or fair treatment issues identified by members, the interviewers assessed if due process was followed. Support questions attempted to elicit information from case managers on whether procedures for addressing the member's concerns were implemented, and if the procedures were consistent with due process principles.

The table below shows the 2003 findings from the member outcome interviews related to member rights:

Outcomes Related to Member Rights – 2003 Aggregate Findings

<i>Family Care Outcome</i>	<i>Outcomes Met</i>	<i>Supports Present</i>
People have privacy.	91.04%	83.30%
People are respected.	72.30%	72.71%
People are treated fairly.	73.73%	70.88%

Privacy, respect, and fair treatment seem to be fundamental beliefs held by all CMO interdisciplinary teams (IDTs). Privacy was the number one outcome reported as being met by CMO members and had the highest percentage of supports present. However, outcomes and supports related to respect and fair treatment were met less frequently.

Quality Site Reviews

The 2002 CMO Quality Site Review concluded that internal (local level) grievance policies and procedures were not being implemented across all CMOs according to CMO contract requirements. Therefore, the 2003 quality site review focused on grievance systems. The DHFS reviews and approves each CMO's internal appeal and grievance policy prior to implementation in accordance with the contract between DHFS and each CMO (Sect. IV; F:46). All CMOs have a DHFS approved notice of action form which details the CMO's intention to deny, limit, reduce, suspend, or terminate a service, and includes information on how to appeal the CMO's decision. To determine if the CMO supported members in exercising their rights, the following were some of the questions asked during the on-site visit:

- Describe a time when a member's appeal or grievance was successfully resolved by the team informally (prior to convening the grievance committee).
- Share an example of when the CMO grievance and appeal resolution decision to deny a service was reversed through the state fair hearing process.
- Describe how the CMO monitors appeals, grievances and state fair hearings for trends.

The resource allocation decision-making (RAD) method is DHFS's recommended tool for IDTs when making decisions about services and supports for members. The RAD provides a uniform

process for IDTs to follow when working through the decision-making process with members. This tool provides a consistent format to follow for all members, yet allows each team to consider a member's personal outcomes in relation to the services and supports being considered. The RAD process is being used, but it is not being used consistently within or among all CMOs. For example, some teams may apply the RAD method informally during discussions with the member. Other teams have a worksheet with a series of questions related to the member's outcomes that they use to guide them through the decision-making process. Some teams document specific steps leading to decisions, while other teams use the RAD method, but do not document it. Some IDTs refer to the RAD method as a decision-making process that considers a member's "needs", while other IDTs refer to it as a process that considers a member's "outcomes".

CMOs indicated that they ensure that members are aware they can request and obtain assistance in filing an appeal or grievance. All CMOs indicated that they had not experienced a request for an expedited review or resolution of an appeal or grievance; however, they all indicated that policies and procedures were in place to handle requests for expedited reviews or resolutions.

Richland and Portage CMOs revised their appeal and grievance policy and procedures in 2003 to ensure clarity for both CMO members and staff. In Portage County and La Crosse County the IDTs attempted to personally contact members when service requests were not authorized, to ensure they understood the reasons and what actions they could take in response. They also conducted follow-up with written notifications. Staff at several CMOs indicated that they possess good negotiation and mediation skills, which they feel may reduce the number of formal appeals and grievances filed at the CMO level. The Richland CMO provides continual education for IDT staff related to the appeal and grievance process. The Member Relations Coordinator and Provider Network Developer attend regular IDT meetings to discuss issues or concerns regarding the internal CMO process. At one of the Care Management Units (CMUs) in the Milwaukee CMO, IDTs copy the portion of the member handbook related to appeals and grievances and provide copies to members as part of their six-month planning process.

Providing information to members on how to access the grievance system continues to be an area for improvement for most CMOs. Notices of action are still not being issued consistently across all CMOs and members are; therefore, not informed of their right to file an appeal or grievance.

The contract between the CMOs and DHFS specify that logs of appeals, grievances and state fair hearings be submitted to DHFS annually for review. CMOs are submitting these logs as required; however, they are not using this information internally to explore trends related to member rights (Sect. X; B:104).

MCAP Reviews

MCAP reviews provide information that helps determine whether CMOs are providing support to members in exercising their rights by providing notices of action to members when service requests are denied or limited and when services are reduced or terminated by the CMO.

The table below lists individual and aggregate findings for the 2003 MCAP criteria related to participant rights:

2003 MCAP Criteria Related to Participant Rights

<i>Criterion</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
Issuing notices of action when indicated and in a timely manner.	91	100	97	97	100	96

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

Findings from the 2002 MCAP reviews suggested that members may not have been informed of their right to appeal or grieve decisions made at the CMO level. Some CMOs indicated that they were unsure of when notices of action were required and may not have been issuing the notices when indicated. During 2003 MCAP reviews revealed CMO's had improved in issuing notices of action to their members.

Providing notices of action consistently is still an area that should continue to be a priority for improvement and/or sustained performance, given that the notice of action is one way to advise members of their appeal and grievance rights pertaining to service decisions.

During the second quarter of 2003, there was one other issue involving member rights identified at the Fond du Lac CMO. This issue involved member rights training for providers, along with the need to develop and implement a behavioral treatment plan. The CMO did provide some additional information regarding this member; however, MetaStar and DHFS determined that additional follow-up was indicated. DHFS referred the case to the Bureau of Developmental Disabilities Services, Community Integration Specialist for further follow-up.

Appeals and Grievances

Family Care members have a right to participate in the decision-making process regarding their care and outcomes. When a member enrolls in Family Care, the CMO has a responsibility to provide education to members on the appeal and grievance process within 60 days of enrollment. Additionally, the CMO must provide a member rights specialist to serve as a member rights advocate within the agency. The role of this position is to provide support for all members in understanding their rights and responsibilities related to Family Care, including due process procedures. They also assist members in identifying rights to which they are entitled. If multiple grievances, review or fair hearing mechanisms are available, the member rights specialist assists the member in determining which mechanism will best meet their needs.

In 2003, only one grievance was filed that specifically involved a member rights issue. This involved a member in the physically disabled target group who felt that the CMO was trying to take away his right to privacy by asking him to sign a medical release so the team could talk with his physician. This issue was resolved through team collaboration and negotiation with the member and the CMO.

**Participant Rights and Responsibilities:
Summary and Recommendations from 2003 EQR Findings**

CMOs should continue to provide supports that enhance members' privacy.

While CMOs seem to foster a culture that supports member rights and fair treatment, such as the right to file an appeal or grievance, providing information to members on how to access the grievance system continues to be a challenge for most CMOs. CMOs are still inconsistent in their use of the notice of action form. This may be one reason for the lower findings related to outcomes and supports for fair treatment and respect. Consistent use of the notice of action form would help promote members' rights by providing members with specific information on how to file an appeal or grievance when they disagree with decisions made by the CMO. MetaStar recommends that each CMO review their policies and procedures for issuing notices of action and provide initial and annual training to all staff regarding notice of action requirements. MetaStar also recommends that CMOs develop a process that ensures members are advised of their rights not only upon admission, but on a periodic basis. One example of this would be to use the method of one Milwaukee CMU that involves copying the portion of the member handbook related to appeals and grievances and giving a copy to members at each six month review. A verbal discussion with the member regarding their rights could occur at that time.

MetaStar also recommends that CMOs utilize their internal data to identify patterns or trends related to member rights. One method of doing this would be to develop a process for reviewing adverse notice of action data and appeals and grievances data on a periodic basis to identify any relationship between these two actions this would also assist in determining if current processes are being implemented consistently and are effective in supporting member rights.

Consistent decision-making contributes to fair treatment for all members. Lack of understanding of the RAD process, constant IDT turnover and team changes, and inconsistent documentation of decision-making processes may be factors contributing to the inconsistent use of the RAD method. MetaStar recommends that all new CMO care managers and nurses receive RAD training as part of their orientation program and that all CMO staff receive annual RAD training. MetaStar also recommends that each CMO develop a process for reviewing a sample of approvals and denials to evaluate how their IDTs are using the RAD method for decision-making. MetaStar also recommends that each CMO require IDTs to use a standard worksheet that will prompt teams through the decision-making process and require IDTs to document the decision-making process consistently.

Domain: Participant-Centered Service Planning and Delivery

“Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decision concerning his/her life in the community.”

Participant-Centered Planning and Delivery: 2003 EQR Findings

Member Outcome Interviews

During the 2003 member outcome interviews, members were asked about the choices they had in where and with whom they lived, their employment options, their daily routines, and the services they received. Questions were also asked of members that provided information on whether members felt they had continuity and security in their lives, whether they felt connected to an informal support network, and whether they felt they were able to participate in their communities to the extent that they wished. This information served as a basis for determining whether seven of the 14 Family Care outcomes had been met by members and if there were adequate supports present to help them meet these outcomes. The table below lists these outcomes and how they integrate with the CMOs’ service planning and delivery functions, along with the findings from the 2003 member outcome interviews.

Outcomes Related to Service Planning and Delivery – 2003 Aggregate Findings

Family Care Outcome	Participant-Centered Service Planning and Delivery Implications	Outcomes Met	Supports Present
People choose where and with whom to live.	Member-centered plans should incorporate the member’s preference for living arrangements and should address any barriers, when identified that prevent the member from choosing where and with whom to live.	56.42%	50.51%
People choose their services.	IDTs can help members explore their preferences about services and providers, and explore options with the member. Member-centered plans should reflect the member’s choices and preferences.	45.42%	43.18%
People choose their daily routine.	During the service planning process, IDTs can support members in choosing daily routines and activities and then incorporate these choices into a plan that honors them.	73.52%	71.28%
People experience continuity and security.	IDTs can offer support to members by learning what continuity and security means to a member and identifying situations where these may be lacking. If factors are present that decrease the member’s feelings of security and continuity, the IDT can then develop a plan that will help the member achieve continuity and security.	56.82%	54.38%
People remain connected to informal support networks.	IDTs should obtain information about a member’s informal support network and try to determine if the member is satisfied with the amount of contact they have with their network. IDTs should be aware of the member’s natural support network and know the status of relationships within it.	65.17%	63.54%
People achieve their employment objectives.	IDTs can support members by learning about the member’s work interests and providing them with options for work experiences. Part of this process involves identifying barriers that the member may be experiencing, and developing plans that address those barriers.	58.04%	52.75%
People participate in the life of the community.	Members should have access to, and should be able to participate in community activities to the extent that they desire. IDTs help members achieve this outcome by learning the member’s interests and developing a support plan that helps the member participate in community activities according to their preferences and interests.	56.01%	57.64%

Several of the above outcomes were only met for slightly more than half of the members interviewed, including the outcomes related to people choosing where they live, people experiencing continuity and security, people achieving their employment objectives, and people participating in the life of the community. The highest outcome met was for people choosing their daily routine, but was still only met for 73 percent of those interviewed. The outcome that was met the least often was the outcome related to people choosing their services.

Quality Site Reviews

In 2002, it was noted that CMOs lacked well-developed and well-implemented Self Directed Supports (SDS) workplans, SDS training for staff and members, and policies and procedures for completing criminal background checks on individuals applying to be a person's SDS worker. During 2003, DHFS requested and received periodic reports describing the CMO's progress in implementing SDS, and any challenges or barriers faced related to SDS services.

Substantial progress has been made related to SDS, specifically in the area of developing and implementing an SDS workplan. The IDTs assist members with establishing SDS for services to allow members more choices of providers. SDS services are able to be combined with providers within the La Crosse CMO's provider network to ensure that member needs are met. For example, a member had arranged through SDS for an individual to assist with supportive home care Monday through Friday, and for services on the weekend the member chose to use a provider within the CMO's provider network. However, quality monitoring of SDS providers was not well-developed at the Portage CMO.

The 2003 Annual CMO Quality Site Review attempted to discover whether the CMO offered members options for services and interventions while respecting their wishes and preferences regarding service selection. To assist in determining if the CMO services and supports were planned and effectively implemented in accordance with each member's unique needs and expressed preferences, the following were some of the questions asked during the on-site visit:

- Share an example of how a team successfully involved a member when there was a change in service provider, change in type or amount of a service or the coordination of their services.
- Starting with how a member chose an IDT at enrollment, describe a time the team authorized, arranged, provided and/or coordinated services effectively for a member.
- Share an example of when a choice of services was available to a member with urgent care needs.
- Describe how the CMO supervisors/managers monitor for consistency in decision-making across IDTs.

The Portage CMO and Fond du Lac CMO instituted internal processes to monitor timeliness of care planning which will target improvement activities and assist them in policy development. The remaining CMOs could benefit from similar practices. Case management teams and relationships with community entities have been developed to assist members with specific needs.

The Fond du Lac CMO described a process they undertook when streamlining their Provider Network, where they supported member preferences for providers before any provider was removed from the network. The Richland CMO empowers the IDTs to do member-centered planning, and the staff are able to be flexible and respond quickly to meet member needs. Staff at the Fond du Lac CMO described a situation when a member's preference for his living situation was in conflict with his guardian's preference. The team supported the member's MetaStar, Inc.

preference, sent a notice of action form to his guardian, and was ultimately successful in moving him to his preferred living arrangement. Specialty case management teams that specialize in assisting members with mental health, AODA and behavioral concerns have been developed in La Crosse and Fond du Lac. The Milwaukee CMO has coordinated with the Service Access to Independent Living unit to advise teams and to address issues related to mental health services. Retrospective peer review chart audits occur in Fond du Lac and Milwaukee CMOs. The Portage CMO has transitioned from a manual retrospective chart review to an automated process with built-in prompts for IDTs when they open member records, and reports are generated for IDT supervisors.

IDTs expressed some discomfort in communicating negative decisions to members and in negotiating service changes with members. During 2003, DHFS did provide training for IDTs on negotiating skills and conflict resolution.

CMOs are striving to provide a member-focused and member-centered approach to care planning and care management service. IDTs value and maintain strong connections with members and their families and informal supports, as well as with providers. Members are made aware of the ability to choose from different providers through information contained in the provider network directory, however, it was determined that the Milwaukee CMO and the La Crosse CMO did not distribute updated copies of the directory to members in a timely manner. IDTs involve members in decision-making about services on plans of care on a consistent basis at all CMOs.

MCAP Reviews

DHFS has specified certain requirements in its contract with CMOs regarding the assessment and planning processes for new Family Care enrollees. These requirements help ensure that Family Care members are receiving timely and comprehensive assessments that can be used in the development of initial and individualized member-centered plans.

Each Family Care enrollee is part of a team, which at a minimum comprises the member, a registered nurse, and a social services coordinator. DHFS' contract with CMOs identifies several standards and requirements that help assure quality, timeliness, and a member-centered approach to service planning. Service planning in the Family Care program not only involves the member, but when needed and desired by the member, includes family, friends, formal supports and informal supports.

The IDT is responsible for assuring that all needed services and supports, whether covered under the Family Care benefit or not, are in place for the member. This may include arranging covered services, along with coordinating and/or referring for non-covered services. IDTs are also responsible for ensuring that services and supports specified in a member's plan are actually being provided to the member, and for monitoring the effectiveness of all services and supports. Every Family Care member is required to have their plan reviewed and/or updated periodically and to be reassessed when their situation or condition changes significantly.

The table below lists individual and aggregate findings for the 2003 MCAP criteria related to the assessment process:

2003 MCAP Criteria Related to Assessments

<i>Criterion</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
Comprehensive social and health assessments were completed.	100	100	100	100	100	100
Comprehensive social and health assessments were completed in a timely manner.	81	71	100	100	95	88
Comprehensive social and health assessments address and assess all needs identified during the LTC FS process.	100	100	100	100	100	100

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

The table below lists individual and aggregate findings for the 2003 MCAP criteria related to service planning:

2003 MCAP Criteria Related to Service Planning

<i>Criterion</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
Having a RN and SSC collaborate during the assessment and planning process.	88	93	98	90	98	92
Identifying and addressing member preferences.	99	100	99	93	97	97
Including members/guardians, family, and formal/informal supports in the planning process.	98	96	100	100	96	98
Ensuring that members are in agreement with their plan.	100	100	100	100	100	100
Completing an initial service plan within 10 days of enrollment.	74	94	100	71	89	83
Completing a comprehensive member-centered plan within 60 days of enrollment.	74	88	86	90	89	83

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

The table below lists individual and aggregate findings for the MCAP criteria related to service delivery:

2003 MCAP Criteria Related to Service Delivery

<i>Criterion</i>	<i>MKE</i>	<i>RCH</i>	<i>FDL</i>	<i>LAX</i>	<i>PTG</i>	<i>Aggregate</i>
Performing reassessments when indicated.	100	100	99	99	98	99
The CMO offers/assists with coordinating and/or arranging all needed services and supports.	93	97	99	96	100	96
Determining if service reductions or terminations are appropriate.	100	100	100	100	100	100
Developing and implementing a member-centered plan that addresses all service and support needs and that is updated when the plan either fails to achieve the member's outcomes or when the member's condition or situation changed significantly.	100	100	99	100	100	100

Note: The values listed represent the % of plans reviewed in 2003 that met the criteria or that were not applicable.

In 2002, all CMOs had difficulty meeting contract requirements related to specific timeframes for assessment and planning activities for new members. Most CMOs had initiated internal monitoring and tracking systems for these timeframes; however, they varied in their approach and frequency of monitoring. Also during the fourth quarter of 2002, an intensified review was conducted at the La Crosse County CMO in response to a health/safety concern that had been identified during the prior quarter's review. Several concerns with the timeliness of assessment and planning activities, along with several other organizational concerns were identified and referred to the DHFS for further follow-up. La Crosse County CMO developed a corrective action plan to improve its timeliness of service planning. This plan also included hiring a consultant to evaluate and assist the CMO to develop an infrastructure that supports members in achieving their defined outcomes. To date, the CMO has hired and is working with consultants to achieve this goal.

In 2003, Milwaukee CMO, Richland CMO and Portage CMO were still not meeting the required timeframes for completing comprehensive assessments (within 30 days of enrollment). Milwaukee CMO, Richland CMO, Portage CMO, and La Crosse CMO were not able to consistently meet the required timeframes for completing initial service plans (within 10 days of enrollment). No CMOs were consistently meeting the required timeframes for completing individualized member-centered plans (within 60 days of enrollment).

During the second quarter of 2003, Richland CMO was advised to perform an analysis of its effectiveness in providing timely assessments and planning for its members. The CMO had already developed an internal monitoring system for this purpose, and therefore, a corrective action plan was not requested. They are currently continuing to track the timeliness of their assessments and MCPs/ISPs.

Milwaukee CMO was required to initiate a corrective action plan during the third quarter of 2003 in an effort to improve the timeliness of assessment and planning for its members. The CMO developed a corrective action plan that consisted of developing internal monitoring systems to evaluate the timeliness of their assessment and planning processes. Their plan also included a step to identify barriers preventing timely assessments and planning. The CMO is currently

monitoring their performance in these areas and is providing monthly progress reports to DHFS and MetaStar.

All CMOs have systems and processes in place that support a member-centered approach to service planning, which includes involving members and other family, friends and supports in the planning process. CMOs also developed individual plans that incorporated members' preferences and personal outcomes.

CMOs have processes in place that support ongoing assessment, coordination, and monitoring of service plans. Members had appropriate plans in place, which identified service and support needs necessary to achieve their personal outcomes, and these plans were reviewed and updated as necessary. When the CMO reduced or terminated services, it appeared that these actions were appropriate.

For a complete summary of all 2003 CMO-specific and aggregate MCAP review findings, please refer to Appendix D.

Appeals and Grievances

Member decision-making is an important component of the Family Care program, and members are encouraged to be an integral part of the Family Care team. Often, the member may feel as though they are in disagreement with the plan that the team is presenting. An appeal or grievance is a formal venue for the member to express their dissatisfaction with their plan or services.

Appeal and grievance investigations included service plan complaints and complaints regarding requested services, such as denials of service, payments for service, limited authorizations of a variety of types, and disagreement with service plans. Generally, disagreement with service plans was related to member's choice of where and with whom to live. Reductions or denials in services or DME were also areas that were investigated.

The following table shows a breakdown by target group of the reasons for appeals and grievances in 2003:

Appeals and Grievances Overview CY 2003

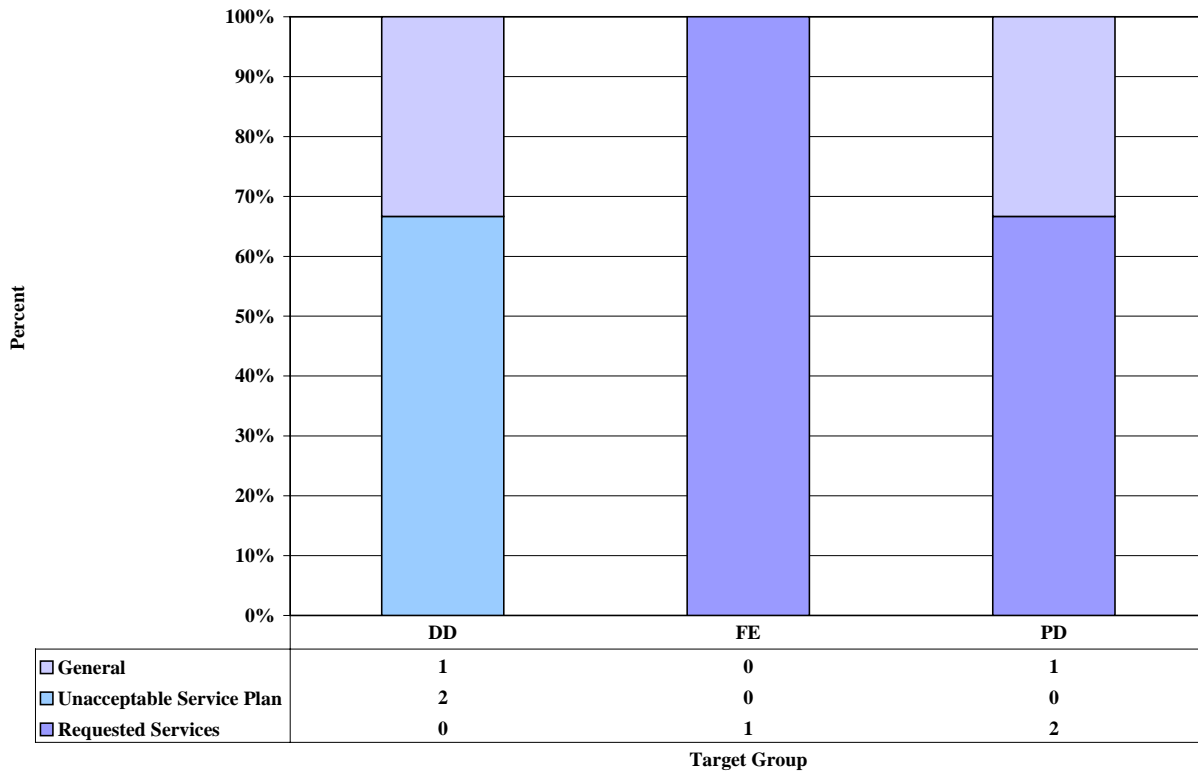
Target Group	A/G Reason						All Categories
	Eligibility	Requested Services	Unacceptable Service Plan	CMO Process	General	Unknown	
DD	0	1	3	0	1	0	5
FE	52	11	3	0	0	1	67
PD	11	7	0	0	1	0	19
Total	63	19	6	0	2	1	91

Further analysis of the category of "requested services" showed that the majority of appeals and grievances related to requests for service involved requests for supportive home care (eight occurrences) and requests for needed equipment, such as DME, adaptive aids, and/or home modifications (five occurrences).

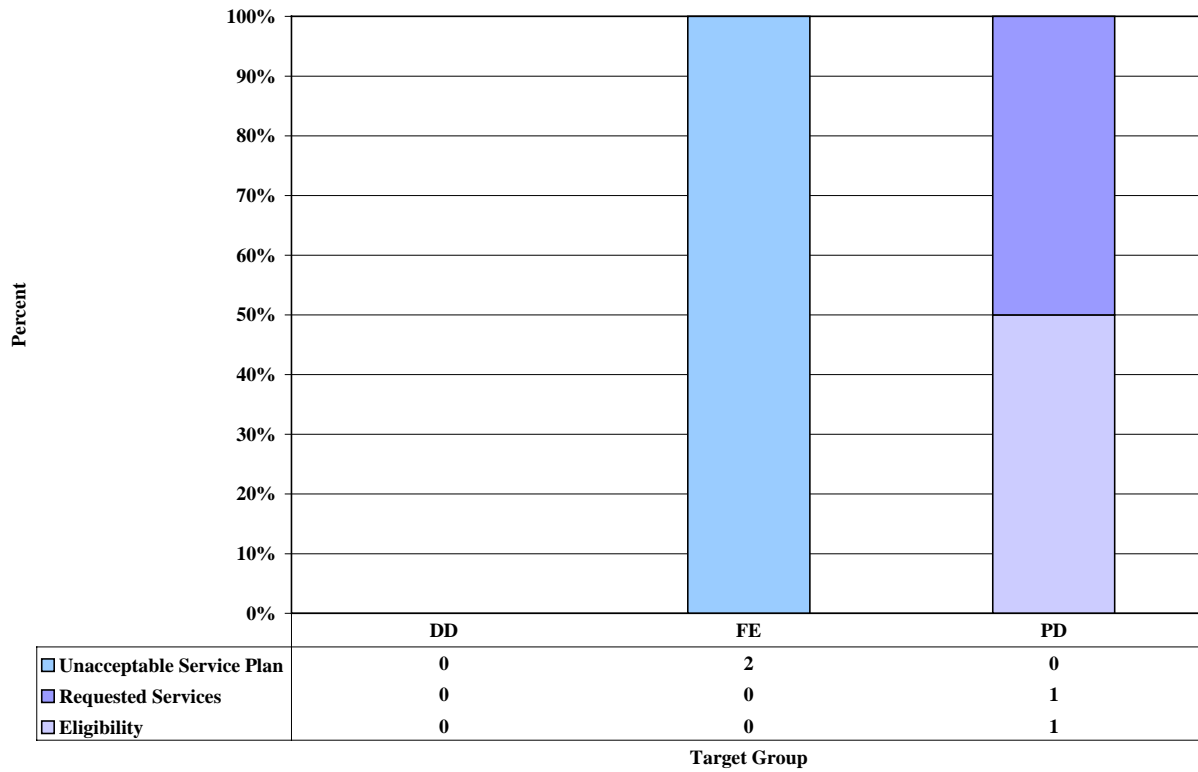
The breakdown of appeals and grievances is displayed by target group and category for each county. No data display is included for Portage County, which had only one grievance received in 2003. The grievance was made by a member in the Physically Disabled target group, and it was related to a requested service. Additionally, Richland County only had two grievances

received. One of these was in the Frail Elderly target group and related to an unacceptable service plan. The second grievance received for Richland County was in the Physically Disabled target group and was related to a requested service.

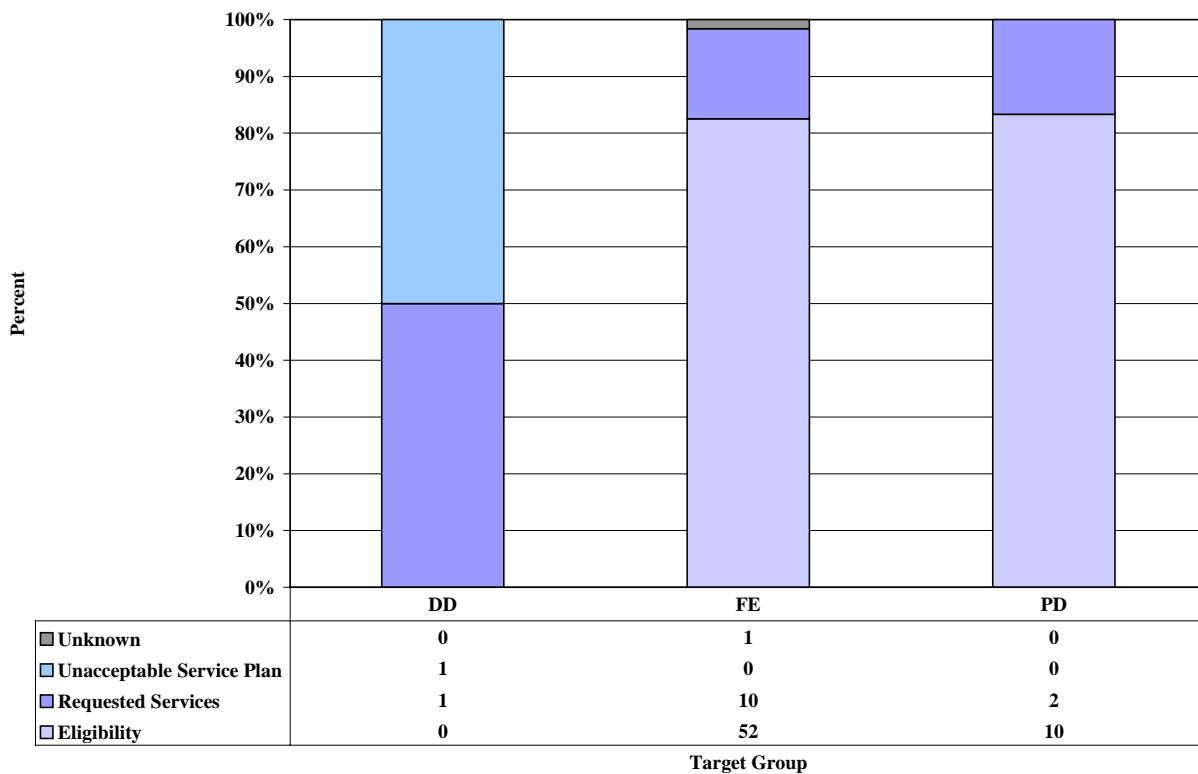
Fond du Lac CY 2003 Appeal & Grievance Reasons by Target Group



La Crosse CY 2003 Appeal & Grievance Reasons by Target Group



Milwaukee CY 2003 Appeal & Grievance Reasons by Target Group



The following table shows a breakdown for all appeals and grievances that were reviewed and resolved by MetaStar in 2003:

Appeal and Grievance Resolutions – by CMO County

July 1, 2003 – December 31, 2003

CMO	MetaStar Review	Resolution Obtained	Concurrent Review	Resolution Obtained
Fond du Lac	5	3	1	1
LaCrosse	1	1	2	1
Milwaukee	8	3	9	3
Portage	1	1	0	0
Richland	1	1	1	0
TOTAL	16	9	13	5

Total Reviewed	29
Total Resolved	14

Since being authorized to conduct reviews in July 2003, MetaStar has investigated 29 appeals or grievances. Of these 29, 16 were DHFS level reviews. Nine of these were resolved to the member's satisfaction. The other 13 were concurrent reviews and five of these were resolved to the member's satisfaction. The majority of cases where resolution to the member's satisfaction was not obtained occurred in Milwaukee County. Milwaukee's lower rate of resolution was related to their preference for the more formalized decision-making process at the state fair hearing level.

**Participant-Centered Service Planning and Delivery:
Summary and Recommendations from 2003 EQR Findings**

Although CMOs have made substantial progress with implementing the SDS option for members, MetaStar recommends that each CMO develop and implement a quality-monitoring process for its SDS providers.

CMOs have systems and processes in place that support a member-centered approach to service planning, however, outcomes related to service planning and choice were not often met for members. One factor that might be contributing to the lower rates for outcomes related to members' choice of where to live, daily routines, services provided and employment opportunities is the amount of time it takes for service planning and the amount of time it takes to authorize and implement services and supports of the member's choice. The CMOs contract with DHFS sets forth specific requirements for the timeliness of assessment and care planning (Sect. 3, B, 5-8). When these functions are delayed, needed services may also be delayed. Also, once a plan is developed, if it is not implemented in a reasonable timeframe, members may feel that their choices are not being honored. For example, if a member wishes to live in a particular adult family home (AFH), but there is a delay in approving the facility or the CMO is untimely in coordinating the move; the member may perceive this as not having their choice honored. Another example is that if an IDT approves grab bars for the member, but then is untimely with ordering and following through to get them installed, the member may perceive this as not having their choice for grab bars honored. Another factor could be that members are not being given updated provider information in a timely manner.

One factor that may have influenced the lower percent of outcomes met for continuity and security is the CMO practices of reassigning members to different IDTs when staff turnover occurred or when new teams were added.

MetaStar is recommending that each CMO:

- Perform a utilization review of member services and an analysis of the provider network to determine if members are being provided with adequate choices for living arrangements and service providers.
- Implement an internal process for monitoring the timeliness of assessments and care plans on a periodic basis, if one is not already in place.
- Develop a procedure for ensuring that members get updated copies of provider directories in a timely manner.
- Develop timeliness standards for the provision of services and supports.

MetaStar is also recommending that DHFS conduct a focused review of the timeliness of assessment and care planning functions at all CMOs in 2004.

Domain: System Performance

“The system supports participants efficiently and effectively and constantly strives to improve quality.”

System Performance: 2003 EQR Findings

Quality Site Reviews

In 2002 CMOs had detailed workplans for internal quality assurance and improvement activities, but significant portions of the planned activities had not been implemented or completed. Some CMOs lacked data systems capable of capturing or analyzing reported information.

The 2003 Annual CMO Quality Site Reviews attempted to discover if CMOs had systems in place to collect and analyze data related to quality activities, and to implement and monitor quality improvement activities. To assist in determining this, the following were some of the questions asked during the on-site visit:

- Provide an example of positive changes in a member’s life when culturally competent providers were accessed.
- Share with us how the CMO successfully monitors their process for authorization of requested services.
- Describe how the CMO monitors contracted providers to determine if they are effectively meeting DHFS and CMO standards.
- Describe a time when the CMO has successfully improved the continuity and coordination of care for members receiving services outside the benefit package.

CMOs have subcontracted for special expertise in the areas of home modifications, purchasing of durable medical equipment, and therapy services and assessments to allow IDTs to focus on care coordination and care planning. Guidelines have been developed to assist teams in decisions regarding appropriateness and frequency of certain services, and when to refer for assessments by specialty providers, such as physical therapy. The Richland CMO creates opportunities for teams to discuss decision-making in a team forum, which results in the identification of improvement opportunities. The Milwaukee CMO has partnered with Community Care for the Elderly to establish standards for assessing nursing home quality.

In order to contain costs, the Portage CMO developed and implemented automated claims edit checks for monitoring the service authorization process related to paying claims. This monitoring activity has promoted consistency in paying only claims that have prior authorization from the teams. The computerization of care management assessments and forms allows administration at the Fond du Lac CMO to monitor the quality of care management services and how resources are being used. The La Crosse CMO has developed community partnerships to assist in the collection of data. For example, they utilize local college students to support data collection for a CBRF reference tool and in planning prevention activities for the Prevention and Wellness program.

Through monitoring timelines associated with care planning, the Portage CMO identified difficulty with meeting the requirement of contacting the member within the first three calendar days of enrollment. To improve performance in this area, the CMO worked with the resource center to develop an early notification process for pending enrollments so that team assignments

could be made prior to enrollment. As a result, members are sometimes contacted by the CMO to begin planning enrollment.

CMOs are participating in DHFS' efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. For example, member handbooks are being made available in several languages common to the CMO's geographic region. The Milwaukee CMO has recognized the need for cultural competency and has made great strides to develop culturally diverse Care Management Units (CMUs). Staff members from two CMUs, which primarily serve members of Russian and Hispanic descent, actively participate in provider education and worker recruitment to support the special communication needs of members with limited English proficiency. In La Crosse, the Adult Family Home program is monitored by a Hmong-speaking service aid, and the CMO has contracted with a home care agency specializing in serving the cultural needs of the Hmong community. The Fond du Lac CMO relays considerations regarding cultural sensitivity to all staff and providers as it relates to the religious order of nuns enrolled in the CMO.

The CMOs are adept at collecting data for analysis. They are just beginning to recognize that the collection and use of quality monitoring data will enable them to determine if they are achieving their Quality Assurance/Quality Improvement program objectives. They are also starting to recognize that this data can provide them with accurate information in order to carry out effective workplans.

Validation of CMO Reported Performance Measures

Three of the many elements that affect the quality of Family Care members' lives are care management team turnover and vaccination for influenza and pneumonia. High turnover rates reduce continuity of care for members and failure to be vaccinated exposes members to avoidable health risks.

In 2002, validation activities served as a learning exercise for future rounds of indicator reporting. All CMOs collected and reported data for three performance measures – care management turnover rates, influenza vaccination rates, and pneumonia vaccination rates.

All CMOs reported credible turnover data; however, most CMOs did not report credible vaccination data. The problems that were identified with most CMOs' vaccination data were significant enough to prevent the calculation of useful rates. In every CMO, it was found that processes and procedures were informal and unwritten and depended on the memories of individual CMO staff members.

Performance Measure Rates

Care management team turnover was reported as the percent of the care management team members who separated during the calendar year 2003. The care management team was defined as two groups; case managers and registered nurses, which were reported separately. The CMOs calculated the rates for this performance measure.

For the 2003 contract year, vaccination rates for influenza immunization were calculated among members who were continuously enrolled from September 1, 2003, through December 31, 2003 – the period during which current influenza vaccinations would have been received. The influenza vaccination rate was calculated as the percentage of these members who were known by the CMO to have received an influenza vaccination during that period. The pneumonia vaccination rate was calculated as the percentage of members who were known by the CMO to

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have received a pneumonia vaccination within the past 10 years (on or after January 1, 1993). The pneumonia vaccination rate was calculated among members who were continuously enrolled from July 1, 2003, through December 31, 2003. It should be noted that vaccinations are not among the services covered in the Family Care benefit package, but coordination of long-term care with preventive health services is. Family Care case managers are expected to check on members' health services, such as vaccinations to ensure that members stay as healthy as possible.

Performance Measure Validation

Performance measure validation was performed to verify that the processes and procedures used by the CMO were likely to produce performance measure data that was accurate, reliable, and free from bias. MetaStar, in collaboration with DHFS, developed a list of quality characteristics to assess CMO processes and procedures for reporting performance measure data. Procedures were also developed that specified validation activities and detailed proper use of working documents.

The table below shows the findings of the quality of each CMO's processes and procedures for each performance measure. (Appendix E also explains the quality characteristics shown below and how reviewers determined if they were present.)

Quality Characteristic	Performance Measure	Characteristic Present? (Yes/No/NA)				
		CMO County				
		Fond du Lac	Portage	Milwaukee	Richland	La Crosse
Correctly collecting and entering data	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	Yes	Yes	Yes	Yes	Yes
	Pneumonia Vaccination	Yes	Yes	Yes	Yes	Yes
Correctly combining data from multiple sources	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	Yes	Yes	Yes	Yes	Yes
	Pneumonia Vaccination	Yes	Yes	Yes	Yes	Yes
Catching and avoiding mistakes in preparing data reports	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	Yes	Yes	Yes	Yes	Yes
	Pneumonia Vaccination	Yes	Yes	Yes	Yes	Yes
Correctly identifying the denominator	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	NA*	NA*	NA*	NA*	NA*
	Pneumonia Vaccination	NA*	NA*	NA*	NA*	NA*
Correctly identifying the numerator	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	Yes	Yes	Yes	Yes	Yes
	Pneumonia Vaccination	Yes	Yes	Yes	Yes	Yes
Correctly calculating the rates	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	NA*	NA*	NA*	NA*	NA*
	Pneumonia Vaccination	NA*	NA*	NA*	NA*	NA*
Documenting processes and procedures	Care Management Team Turnover	Yes	Yes	Yes	Yes	Yes
	Influenza Vaccination	Yes	Yes	Yes	Yes	Yes
	Pneumonia Vaccination	Yes	Yes	Yes	Yes	Yes

*MetaStar calculated these denominators and rates

Rates for care management team turnover

The table below shows the rates of team turnover for care managers and registered nurses, which were reported by each CMO:

Care Management Team	Turnover Rates by CMO				
	Fond du Lac	Portage	Milwaukee	Richland	La Crosse
Case Managers	4.3%	0%	16.0%	25.0%	7.7%
Registered Nurses	23.8%	0%	14.1%	25.0%	5.3%

The MetaStar review team assessed the processes and procedures each CMO used to calculate these rates. Reviewers did find sufficient written documentation at each CMO of the processes and procedures used in preparing them.

Rates for influenza and pneumonia vaccinations

Each CMO reported the number of members known by the CMO to have been vaccinated. From the data reported by each CMO, MetaStar was able to calculate usable rates for all CMOs. The reviewers used a one-tailed t-test to determine acceptable disagreement rates using a 95 percent acceptable minimum standard. It is important to note that additional members may have received vaccinations without the CMO's knowledge. The tables below show each CMO's vaccination rates, by target group, that were calculated by MetaStar:

Influenza Vaccination Rates by Target Groups

Target Group	Fond du Lac	Portage	Milwaukee	Richland	La Crosse	Aggregate
Frail Elderly	74.1%	80.6%	72.6%	80.5%	73.4%	73.4%
Physical Disabilities	57.0%	59.4%	66.7%	51.5%	51.9%	54.9%
Developmental Disabilities	56.9%	54.5%	85.0%	42.2%	52.7%	54.0%
All Target Groups	65.5%	68.0%	72.6%	60.6%	60.2%	68.7%

Pneumonia Vaccination Rates by Target Groups

Target Group	Fond du Lac	Portage	Milwaukee	Richland	La Crosse	Aggregate
Frail Elderly	57.6%	10.5%	62.8%	27.1%	64.3%	58.9%
Physical Disabilities	41.5%	4.0%	60.4%	26.6%	44.3%	37.0%
Developmental Disabilities	22.1%	4.0%	64.7%	20.5%	24.2%	19.9%
All Target Groups	42.6%	7.1%	62.8%	24.7%	45.6%	50.9%

Most CMOs made significant improvements in documentation since the previous year's reporting period. Three of the five CMOs' processes for collecting and reporting all three measures had been formally documented in standard operating procedures. One CMO's processes for collecting and reporting immunization measures had also been more formally documented and one CMO's processes for collecting and reporting the staff turnover measure had been formally documented in standard operating procedures.

Performance Improvement Projects

In 2003, MetaStar, the DHFS and CMOs met to explore implementation of the 'Best Clinical and Administrative Practices' (BCAP) quality framework. MetaStar staff produced a handbook prior to the first meeting to assist CMO quality teams in preparation of implementing the BCAP framework. The first step for CMOs was to form a team that included a Senior Leader, a System Leader, a Project Champion, and a Day-to-Day Leader. The handbook also defined and gave examples of aim statements, measures using a numerator and denominator, and change strategies, the basic components of the BCAP model. It also proposed a worksheet using the four phases of the process, identification, stratification, outreach, and intervention. Each CMO team was expected to bring a project idea to the first meeting.

In June 2003 the first learning session initiated the BCAP collaborative model of quality improvement for the CMOs. A quarterly meeting schedule was determined. Quarterly meetings were a mix of education and training on use of the model and related components, such as rapid-cycle improvement, and an opportunity for teams to have intensive assistance from DHFS and MetaStar staff. The quarterly sessions were supplemented with monthly conference calls focused entirely on work progress. At these meetings, and at other times as requested, teams received technical assistance and guidance in conducting their projects and following the BCAP model. In between these meetings, CMO quality teams worked on their projects. Prior to each meeting the team prepared a report detailing their aims, measures, and progress on their selected project.

At year's end all five CMO quality teams had been formed and had projects underway. The initial projects were as follows:

<i>Fond du Lac:</i>	Living setting and quality of life
<i>La Crosse:</i>	Reducing the complications of diabetes
<i>Milwaukee:</i>	Supporting members' ability to function in the least restrictive setting
<i>Portage:</i>	Improving the IDT's use of congestive heart failure guidelines
<i>Richland:</i>	Substitute Care

The BCAP framework is a complementary combination of data measurement and process that is adaptable to the CMOs' long-term care work. Each CMO created a team that successfully started a BCAP project in 2003. All teams participated in monthly group calls and quarterly workgroup meetings. At the end of the year, the teams decided that they wanted to move toward individual, rather than group, monthly calls, as they felt this would afford them more one-on-one assistance with their projects. The teams also expressed that they liked having a process for quality improvement that they could follow, and they felt that the monthly calls and quarterly workgroups helped keep them on track with their projects. The teams also felt that the process was truly collaborative, with all stakeholders moving in the same direction.

It is expected that more substantive input from the teams and facilitators will be obtained at the end of the first round of BCAP regarding the teams' ability to fully implement this new model, any barriers to doing so, and any new means of supporting and complementing CMOs' performance improvement projects using the BCAP model.

System Performance: Summary and Recommendations from 2003 EQR Findings

In 2002, CMOs did not have data systems in place to support the use of data in quality improvement efforts. In 2003, all CMOs collected valid data regarding immunization and turnover rates, and they all implemented written processes for performance measures. Although the 2003 immunization data was deemed to be valid; the data itself revealed that immunization rates were low across all CMOs. MetaStar recommends that each CMO perform an analysis of their internal processes related to health prevention and wellness and try to identify specific interventions that will contribute to improving the overall immunization rates of members. MetaStar is also recommending that the DHFS set program goals for immunization rates based on the Center for Disease Control (CDC) guidelines.

While all CMOs showed progress with data collection, they still need assistance with analyzing and using data for quality improvement activities. MetaStar recommends that the CMOs continue to obtain technical assistance with their current BCAP projects through quarterly BCAP workgroups and individualized monthly conference calls with the DHFS and MetaStar staff in 2004.

**WISCONSIN FAMILY CARE
MEMBER OUTCOME INTERVIEWS
Round 3 (1/03-5/03)**

Adjusted rates—Overall Report

Number of interviews: 491

Personal Outcome Measure	Adjusted Outcomes Present	Adjusted Supports Present
1. People choose where and with whom to live.	56.4%	50.5%
2. People achieve their employment objectives.	58.0%	52.7%
3. People are satisfied with services.	71.3%	71.1%
4. People choose their daily routine.	73.5%	71.3%
5. People have time, space, and opportunity for privacy.	91.0%	83.3%
6. People participate in the life of the community.	56.0%	57.6%
7. People have personal dignity and respect.	72.3%	72.7%
8. People choose their services.	45.4%	43.2%
9. People remain connected to informal support networks.	65.2%	63.5%
10. People are safe.	70.5%	67.2%
11. People are treated fairly.	73.7%	70.9%
12. People have the best possible health.	55.4%	61.7%
13. People are free from abuse and neglect.	86.2%	74.1%
14. People experience continuity and security.	56.8%	54.4%

The statistical rate adjustment accounts for systematic differences between demographic characteristics of the sample vs. those of its parent population. For example, people with Developmental Disabilities were over-represented in one of the interview rounds. The unadjusted rates and adjusted rates are identical, in situations where the sample is proportional to its parent population, by CMO and by target group.

Appendix B

2003 Resource Center Site Visits Consumer Home Visit Summary

Summary of consumer responses on mail-back survey

(No consumer responses are available from Portage and Marathon counties;
home visits were not able to be scheduled in Kenosha county)

1. Are the hours of the resource centers convenient?

	<u>Yes</u>	<u>No</u>
FDL	x	
La Crosse	xx	
Milwaukee	xx	
Richland	xxxx	
Trempealeau	x	

Comments: L1.) n/a. L2) At anytime was good for me. R1, R2, R4) no comments. R3) The hours are fine for me. T1) no comments. Mill & 2) no comments. F1) I think present hours are adequate. Whatever shift a person is working, there is still time to call during off-work hours.

2. Did staff promptly answer your first phone call?

	<u>Yes</u>	<u>I can't remember</u>	<u>No</u>
FDL	x		
La Crosse	x		
Milwaukee	xx		
Richland	xx		
Trempealeau	x		

Comments: L1.) Did not answer to this question. L2) no comments. R1, R4) no comments. R2) walked in. R3) Did not answer this question. T1) no comments. Mill & 2) no comments. F1) no comments

3. If staff called you back, did staff call you promptly and answer your concerns?

	<u>Yes</u>	<u>I can't remember</u>	<u>No</u>
FDL	x		
La Crosse	xx		
Milwaukee	x	x	
Richland	xx		
Trempealeau	x		

Comments: L1 & L2) no comments R1, R4) no comments. R2) did not answer this question. R3) did not check an answer. Comment: I haven't had to call. (?? relevance to question?). T1) no comments. Mill & 2) no comments. F1) no comments.

4. Was the home visit scheduled promptly?

	<u>Yes</u>	<u>I can't remember</u>	<u>No</u>
FDL	x		
La Crosse	x		
Milwaukee	xx		
Richland	xxxx		
Trempealeau	x		

Comments: L1) no comments. L2) did not answer this question. R1, R2, R4) no comments. R3) Right on time. T1) no comments. Mil1&2) no comments. F1) no comments.

5. Did you feel the staff treated you with courtesy and respect?

	<u>Yes</u>	<u>I haven't had enough interaction</u>	<u>No</u>	<u>No</u>
FDL	x			
La Crosse	xx			
Milwaukee	xx			
Richland	xxxx			
Trempealeau	x			

Comments: L1& L2) no comments. R1, R2, R3) no comments. R4) They were very thoughtful and kind ; answered everything I asked. T1) no comments. Mil1&2) no comments. F1) no comments

6. Do you have enough information about services and programs and your choices?

	<u>Yes</u>	<u>Could have been clearer</u>	<u>No</u>
FDL	x		
La Crosse	xx		
Milwaukee	xx		
Richland	xxxx		
Trempealeau	x		

Comments: L1& L2) no comments. R1, R2, R4) no comments. R3) Good work. T1) no comments. Mil1&2) no comments. F1) I had a pretty good understanding prior to calling, but staff added to that.

7. Has the resource center been helpful?

	<u>Yes</u>	<u>No</u>
FDL	x	
La Crosse	xx	
Milwaukee	xx	
Richland	xxxx	
Trempealeau	x	

Comments: L1) no comments. L2) They told me way(s) the resource center could work if we need it. R1) no comments. R2) I was able to get into subsidized housing and in contact with need (ed) medical care-phone, etc. Thank you. R3) Yes, they have been helpful in lots of ways.

R4) Any problem I had they directed me to the people that could help me. T1) informed me of choices. Mill&2) no comments. F1) Unaware of how to access certain services; unaware of how eligibility was actually determined.

8. Did you get what you asked for from the resource center?

	<u>Yes</u>	<u>Don't know what to do</u>	<u>No</u>
FDL	x		
La Crosse	xx		
Milwaukee	xx		
Richland	xxxx		
Trempealeau	x		

Comments: L1& L2) no comments. R1, R2, R4) no comments. R3) Well pleased. T1) no comments. Mill&2) no comments. F1) no comments.

9. What are your plans now that you have the information the resource center provided?**My plans:**

FDL F1) We have not finished the financial screen yet, so I am not yet certain my husband qualifies.

La Crosse L1: Place my father on the list for alternative housing more convenient than his farm. Encourage him to obtain and use the Lifeline system. L2: I will not use it at this time.

Milwaukee Mill & 2: no comments

Richland R1) no comments. R2) Now receiving medical care. R3: My plans are still on hold about moving. R4) Try and stay independent and stay in my home. Be as comfortable as possible and be happier, with less worries.

Trempealeau T1: wait and see

10. Did the services of the resource center meet your expectations?

	<u>Yes</u>	<u>Yes</u>	<u>No expectations</u>	<u>No</u>	<u>No</u>
FDL	x				
La Crosse	x		x		
Milwaukee	x	x			
Richland	xx	xx			
Trempealeau	x				

Comments: L1&L2) no comments. R1, R2, R3, R4) no comments. T1) no comments. Mil1&2) no comments. F1) no comments

11. Would you recommend the resource center?

	<u>Yes</u>	<u>With some reservations</u>	<u>No</u>
FDL	x		
La Crosse	xx		
Milwaukee	x		
Richland	xx	x	
Trempealeau	x		

Comments: L1) The meeting was very information and Shelly Gentry did a nice job. L2) no comments. R1) did not answer this question or comment. R2) no comments. R3) Any time R4) I have told a few of my friends of the help they can get. T1) no comments. Mil1) case worker gave us all information, she was very helpful. Mil2) did not answer this question. F1) Yes, I would recommend the resource center but have not yet had the opportunity to recommend it to someone who needs it.

12. Additional Comments:

FDL F1: I had no clue we might even be eligible for this service so it was good to have thorough explanation of everything.

La Crosse L1: The resource guide is very comprehensive. L2: no comments

Milwaukee

Richland R2) The resource center does a find job in helping people. I was impressed. Keep up the good work! R3) Sorry I've taken so long to get back to you. Hope you find it all O.K. (her name), one thankful lady. R4) no comments

Trempealeau T1: no comments

Appendix C

**FAMILY CARE
ALL SIX DOMAINS
Screener Reliability testing data
Agreement Report for All Screening Agencies**

**Number of screeners: 323
Number of Screening Agencies: 34**

Test results from June, 2003 – September, 2003

Domain	Agreement rate for all agencies
1. Activities of Daily Living (ADL) (17 items)	90.6%
2. Independent Activities of Daily Living (IADL) (8 items)	83.8%
3. Health Related Services (HRS) (6 items)	83.4%
4. Communication and Cognition (7 items)	89.5%
5. Behaviors / Mental Health (5 items)	94.2%
6. Risk (5 items)	91.8%
All Domains	88.9%

Appendix D

Family Care Member-Centered Assessment and Plan (MCAP) Review Review Findings - 2003

Review Period: 1st Quarter, 2003 through 4th Quarter, 2003

MCAP Review Activity for 2003:

Number of MCAP Reviews Completed for 2003 by CMO

County	New/Targeted	Continuing	Total
Fond du Lac	26	47	73
La Crosse	27	70	97
Milwaukee	57	79	136
Portage	25	38	63
Richland	21	14	35
Aggregate	156	248	404

Introduction to MCAP Review Criteria:

The MCAP review criteria used assess three focus areas: timeliness of assessment and planning; continuity of assessment and planning; and member-centered focus of assessment and planning. Below is a summary of each CMO's and aggregate results in each focus area, which represents the averages of all plans reviewed in 2003. Some review criteria elements are not applicable to every plan; therefore, an N/A category is included for these instances.

	<i>Timeliness of Assessment and Planning</i>			<i>Continuity of Assessment and Planning</i>			<i>Member Centered Focus of Assessment and Planning</i>		
<i>CMO:</i>	<u>Met</u>	<u>Not Met</u>	<u>N/A</u>	<u>Met</u>	<u>Not Met</u>	<u>N/A</u>	<u>Met</u>	<u>Not Met</u>	<u>N/A</u>
<i>Fond du Lac:</i>	75.95%	1.91%	22.14%	92.63%	0.98%	6.39%	71.12%	1.67%	27.21%
<i>La Crosse:</i>	72.87%	3.35%	23.78%	90.13%	2.28%	7.59%	67.15%	4.36%	28.49%
<i>Milwaukee:</i>	69.26%	8.38%	22.36%	90.45%	2.88%	6.68%	67.05%	6.19%	26.77%
<i>Portage:</i>	71.62%	2.18%	26.20%	93.20%	0.57%	6.23%	66.67%	3.86%	29.48%
<i>Richland:</i>	73.65%	5.41%	20.95%	91.39%	1.44%	7.18%	69.67%	2.84%	27.49%
<i>Aggregate:</i>	72.07%	4.84%	23.09%	91.28%	1.90%	6.81%	67.98%	4.28%	27.74%

Review Findings

Criterion: *A LTC Functional Screen was completed within the last 12 months, and the member's LOC was documented.*

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (53)	0% (0)	0% (0)
La Crosse	100% (71)	0% (0)	0% (0)
Milwaukee	100% (103)	0% (0)	0% (0)
Portage	100% (46)	0% (0)	0% (0)
Richland	100% (27)	0% (0)	0% (0)
Aggregate	100% (300)	0% (0)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, a LTC Functional Screen must be completed with enrollment and annually thereafter. The findings showed that LTC Functional Screens were completed for all members, when indicated.

Criterion: A comprehensive social and health assessment is completed for all new enrollees..

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	63 % (26)	0% (0)	37% (15)
La Crosse	57% (27)	0% (0)	43% (20)
Milwaukee	76% (57)	0% (0)	24% (18)
Portage	72% (26)	0% (0)	28% (10)
Richland	84% (21)	0% (0)	16% (4)
Aggregate	70% (157)	0% (0)	30% (67)

Summary of Criterion: Per the Department's contract with CMOs, a comprehensive health and social assessment needs to be completed for each new enrollee Findings showed that in 2003, CMOs completed comprehensive social and health assessments for all new members.

Criterion: Comprehensive social and health assessments are completed within 30 days of enrollment.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (21)	0% (0)	0% (0)
La Crosse	100% (21)	0% (0)	0% (0)
Milwaukee	81% (34)	19% (8)	0% (0)
Portage	95% (18)	5% (1)	0% (0)
Richland	71% (12)	29% (5)	0% (0)
Aggregate	88% (106)	12% (14)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, comprehensive health and social assessments need to be completed for each new enrollee within 30 days of enrollment. Findings showed that three of the five CMOs met this requirement $\geq 95\%$ of the time; however, two CMOs have opportunities for improving the timeliness of completing initial comprehensive assessments. Further analysis showed that there were 9 health assessments that were late and eight social assessments that were late. Of the 9 health assessments that were late, 5 plans were 1-2 weeks late; 1 plan was 3-4 weeks late; and 3 plans were 1-3 months late. Of the 8 social assessments that were late, 5 plans were 1-2 weeks late; 2 plans were 1-3 months late; and 1 plans was > 3 months late.

Criterion: Comprehensive social and health assessments were complete and addressed all needs identified in the LTC Functional Screen.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	63% (26)	0% (0)	37% (15)
La Crosse	57% (27)	0% (0)	43% (20)
Milwaukee	76% (57)	0% (0)	24% (18)
Portage	72% (26)	0% (0)	28% (10)
Richland	84% (21)	0% (0)	16% (4)
Aggregate	70% (157)	0% (0)	30% (67)

Summary of Criterion: Per the Department's contract with CMOs, comprehensive assessments for new members must address all the following areas, along with all needs identified in the LTC Functional Screen:

- ADL/IADL's
- Physical Health and Nutrition
- Safety
- Member Rights & Responsibilities
- Personal Values
- Communication
- MH/AODA
- Informal Supports
- Social/Community Integration
- Preferred Living situation
- Education/Vocational
- Economic Resources

The findings showed that all comprehensive social and health assessments addressed all the above identified domains, along with addressing all member needs that were identified in LTC Functional Screens. However, it should be noted that the findings reported above are the findings after the CMO had an opportunity to address/correct issues identified during the 1st and 2nd levels of review. Further analysis of this criterion showed that following the 1st level of review, there were 8 of 157 plans where the initial comprehensive assessments did not address all domains and/or needs.

Criterion: A social service coordinator (SCC) and a registered nurse (RN) participated in the comprehensive assessment process.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (21)	0% (0)	0% (0)
La Crosse	100% (21)	0% (0)	0% (0)
Milwaukee	100% (42)	0% (0)	0% (0)
Portage	100% (19)	0% (0)	0% (0)
Richland	100% (17)	0% (0)	0% (0)
Aggregate	100% (120)	0% (0)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, both a SCC and an RN must participate in the comprehensive assessment process. Findings showed that an SCC and an RN participated in all members' comprehensive assessments.

Criterion: Reassessments are performed when indicated.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	84% (61)	1% (1)	15% (11)
La Crosse	78% (76)	1% (1)	21% (20)
Milwaukee	76% (103)	0% (0)	24% (33)
Portage	79% (50)	2% (1)	19% (12)
Richland	69% (24)	0% (0)	31% (11)
Aggregate	78% (314)	1% (3)	21% (87)

Summary of Criterion: Per the Department's contract with CMOs, reassessments should be performed when the member experiences a significant change in living situation or condition, or when requested by the member or their family, informal/formal supports or providers. Findings showed that, overall, CMOs are performing reassessments most of the time when they are indicated. There were only 3 plans where reassessments were indicated, but not performed. Further analysis of those 3 plans showed that 2 members were not reassess for a change of condition, and 1 member was not reassessed when a request for reassessment was made.

Criterion: Initial service plans (ISPs) are completed and signed by the member within 10 days of enrollment and include all initial service needs.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (21)	0% (0)	0% (0)
La Crosse	71% (15)	29% (6)	0% (0)
Milwaukee	74% (31)	26% (11)	0% (0)
Portage	89% (17)	11% (2)	0% (0)
Richland	94% (16)	6% (1)	0% (0)
Aggregate	83% (100)	17% (20)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, initial ISP's must be completed and signed by the member within 10 business days of enrollment. The initial ISP should list all initial service needs. Findings showed that, overall, this occurred 83% of the time, and that two CMOs met this requirement < 80% of the time. There were 20 instances where initial ISPs were either not completed or signed within the specified timeframes. Of the 20 instances, there were 11 ISPs that were 1-2 weeks late; 2 ISPs that were 3-4 weeks late; 6 ISPs that were 1-3 months late; and one instance where an initial ISP was not completed at all.

Criterion: Individualized member-centered plans (MCPs) are completed and signed by the member within 60 days of enrollment.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	86% (18)	14% (3)	0% (0)
La Crosse	90% (19)	10% (2)	0% (0)
Milwaukee	74% (31)	26% (11)	0% (0)
Portage	89% (17)	11% (2)	0% (0)
Richland	88% (15)	12% (2)	0% (0)
Aggregate	83% (100)	17% (20)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, an individualized MCP must be completed and signed by the member or guardian within 60 calendar days of enrollment. Findings showed that, overall, CMOs met this criteria 83% of the time. One CMO met this requirement < 80% of the time and no CMOs met this criteria > 90% of the time. Of the 20 instances where this criterion was not met, there were 7 MCPs that were 1-2 weeks late; 3 MCPs that were 3-4 weeks late; 4 MCPs that were 1-3 months late; 1 MCP that was > 3 months late; and 1 MCP where it was unable to be determined how late it was. There were 5 MCPs that were completed, but not signed by the member or guardian, and 1 MCP was not completed at all.

Criterion: The MCP/ISP was signed by the member within the last 6 months.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (73)	0% (0)	0% (0)
La Crosse	100% (97)	0% (0)	0% (0)
Milwaukee	100% (136)	0% (0)	0% (0)
Portage	100% (63)	0% (0)	0% (0)
Richland	100% (35)	0% (0)	0% (0)
Aggregate	100% (404)	0% (0)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the MCP/ISP must be reviewed and/or updated, at a minimum, every 180 days. Findings showed that all members' MCPs/ISPs were reviewed and/or updated within the last 6 months. However, it should be noted that the findings reported above are the findings after the CMO had an opportunity to address/correct issues identified during the 1st and 2nd levels of review. Further analysis of this criterion showed that following the 1st level of review, there were 30 of 404 MCPs/ISPs that had not been updated within the last 6 months.

Criterion: The CMO included the member/guardian and other family, friends and formal/informal supports in the assessment and planning process.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	100% (53)	0% (0)	0% (0)
La Crosse	100% (71)	0% (0)	0% (0)
Milwaukee	98% (101)	2% (2)	0% (0)
Portage	96% (44)	4% (2)	0% (0)
Richland	96% (26)	4% (1)	0% (0)
Aggregate	98% (295)	2% (5)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the assessment and planning process should include the member/guardian, and the member's family, friends, and formal/informal supports. All CMOs met this criterion > 95% of the time.

Criterion: The member/guardian received a copy of the MCP/ISP.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	94% (50)	6% (3)	0% (0)
La Crosse	100% (71)	0% (0)	0% (0)
Milwaukee	69% (71)	31% (32)	0% (0)
Portage	93% (43)	7% (3)	0% (0)
Richland	81% (22)	19% (5)	0% (0)
Aggregate	86% (257)	14% (43)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the CMO must provide the member with a copy of their MCP/ISP. Overall, this criterion was met 86% of the time. One CMO met this criterion < 70% of the time. There were 43 instances where the member did not receive a copy of their MCP/ISP. Of these 43 instances, there were 35 cases where there was no documentation regarding the member receiving a copy of their MCP/ISP and 8 cases where the member was offered, but refused a copy of their MCP/ISP.

Criterion: When services were refused, the reason for the refusal was documented and the risks (if any) associated with the refusal were addressed with the member.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	18% (13)	0% (0)	82% (60)
La Crosse	14% (14)	4% (4)	82% (79)
Milwaukee	24% (33)	2% (2)	74% (101)
Portage	9% (6)	5% (3)	86% (54)
Richland	14% (5)	0% (0)	86% (30)
Aggregate	18% (71)	2% (9)	80% (324)

Summary of Criterion: Per the Department's contract with CMOs, the CMO must address risk with members when their choice to refuse a support or service poses a risk to their health or welfare. Findings showed that there were 9 instances where this criterion was not met. In 3 of those instances the reason for refusal was not documented and in all instances, the risk was not addressed with the member.

Criterion: The CMO identifies and addresses member preferences for services and supports in the member's plan.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	99% (72)	1% (1)	0% (0)
La Crosse	93% (90)	7% (7)	0% (0)
Milwaukee	99% (134)	1% (2)	0% (0)
Portage	97% (61)	3% (2)	0% (0)
Richland	100% (35)	0% (0)	0% (0)
Aggregate	97% (392)	3% (12)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the CMO must identify member preferences and incorporate and/or address them in the member's MCP/ISP. Overall, CMOs met this criterion 97% of the time. There were 12 instances where member preferences were not identified and/or addressed on the plan. There were 2 plans where preferences for living arrangements were not identified; 3 plans where preferences were identified, but not addressed on the plan; 5 plans where other preferences were not identified; and 8 plans where other preferences were identified, but not addressed on the plan.

Criterion: The MCP/ISP identified member-centered outcomes that were defined by the member.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	96% (70)	4% (3)	0% (0)
La Crosse	87% (84)	13% (13)	0% (0)
Milwaukee	92% (125)	8% (11)	0% (0)
Portage	94% (59)	6% (4)	0% (0)
Richland	100% (35)	0% (0)	0% (0)
Aggregate	92% (373)	8% (31)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the MCP/ISP should incorporate member-defined outcomes. In the 31 instances where this was not done, 4 plans did not include outcomes, and 27 plans included outcomes, which did not appear to be defined by the member.

Criterion: The SCC and RN worked collaboratively in the planning process.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	98% (52)	2% (1)	0% (0)
La Crosse	90% (64)	10% (7)	0% (0)
Milwaukee	88% (91)	12% (12)	0% (0)
Portage	98% (45)	2% (1)	0% (0)
Richland	93% (34)	3% (1)	0% (0)
Aggregate	92% (277)	8% (23)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, SCCs and RNs should be collaborating throughout the assessment and planning processes. Overall, CMOs showed evidence of this occurring > 90% of the time, with only 1 CMO showing collaboration between SCCs and RNs < 90% of the time. Further analysis showed that there were 10 instances when information-sharing between SCCs and RNs was not evident; 6 instances where joint problem-solving was not evident; and 1 instance where flexible leadership did not occur when indicated.

Criterion: The CMO offered and/or assisted the member/guardian in coordinating and/or arranging all needed services and supports.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	99% (72)	1% (1)	0% (0)
La Crosse	96% (93)	4% (4)	0% (0)
Milwaukee	93% (126)	7% (10)	0% (0)
Portage	100% (63)	0% (0)	0% (0)
Richland	97% (34)	3% (1)	0% (0)
Aggregate	96% (388)	4% (16)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the CMO needs to assure that all needed services and supports are coordinated for the member. This includes covered and non-covered services. There were 13 instances where it did not appear that the CMO assured coordination of non-covered services and 2 instances where it did not appear that the CMO assured coordination of covered services.

Criterion: When member requests were limited or denied, notices of action were sent in a timely manner.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	18% (13)	3% (2)	79% (58)
La Crosse	17% (16)	3% (3)	80% (78)
Milwaukee	9% (12)	9% (12)	82% (112)
Portage	5% (3)	0% (0)	95% (60)
Richland	11% (4)	0% (0)	89% (31)
Aggregate	12% (48)	4% (17)	84% (339)

Summary of Criterion: Per the Department's contract with CMOs, the CMO must issue a notice of action when services are being denied, limited, reduces, or terminated. If the service being changed is a current service, then the notice of action must be issued to the member or guardian at least 10 days prior to the intended action. The findings show that, overall, approximately 1/3 of all cases where a notice of action was indicated, the CMOs did not issue them to members. One CMO did not issue notices of action for any instances when one was indicated.

Criterion: Service reductions or terminations were appropriate.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	26% (14)	0% (0)	74% (39)
La Crosse	18% (13)	0% (0)	82% (58)
Milwaukee	10% (10)	0% (0)	90% (93)
Portage	7% (3)	0% (0)	93% (43)
Richland	11% (3)	0% (0)	89% (24)
Aggregate	14% (43)	0% (0)	86% (257)

Summary of Criterion: Appropriate service reductions were defined as being appropriate if the member's needs changed or if an alternative way of providing the service was identified and agreed to by the member. Overall all service reductions appeared to be appropriate.

Criterion: All identified service/support needs and health/safety issues are addressed, added to the plan, and provided; and the plan explains how all service and support needs and acute and primary care needs are being coordinated; and the plan is updated when it fails to achieve the member's outcomes.

County	Criteria Met % (# of plans)	Criteria Not Met % (# of plans)	N/A % (# of plans)
Fond du Lac	99% (72)	1% (1)	0% (0)
La Crosse	100% (97)	0% (0)	0% (0)
Milwaukee	100% (136)	0% (0)	0% (0)
Portage	100% (63)	0% (0)	0% (0)
Richland	100%	0% (0)	0% (0)
Aggregate	99% (403)	1% (1)	0% (0)

Summary of Criterion: Per the Department's contract with CMOs, the MCP/ISP must address all service and support needs; address all health and safety issues; explain how all service and support needs and acute and primary care services are being coordinated; and be updated if the plan fails to achieve the member's outcomes. Findings suggest that this is occurring 99% -100% of the time. However, it should be noted that the findings reported above are the findings after the CMO had an opportunity to address/correct issues identified during the 1st and 2nd levels of review. Further analysis showed that 91 of 404 plans reviewed were pended after the 1st level of review, due to the MCP/ISP not including some or all of the above criteria.

Unmet Needs / Health and Safety Concerns:

<u>Unmet Needs</u>	# of Occurrences identified following review:		
	<u>After Initial Review</u>	<u>After Re-review</u>	<u>After Corrective. Action</u>
Living Arrangements:	0	0	0
Transportation:	4	0	0
ADL:	2	0	0
IADL:	5	0	0
Career / Voc:	3	0	0
Active tX for DD:	0	0	0
Health-Related Needs:	20	0	0
Communication:	0	0	0
MH / AODA:	3	0	0
DME / DMS:	7	0	0
Continuity Integration:	0	0	0
Other:	10	1	0

Health / Safety Concerns# of Occurrences identified following review:

<u>After Initial Review</u>	<u>After Re-review</u>	<u>After Corrective. Action</u>	
Physical danger in the residence	8	0	0
Unnecessary / Inappropriate medication,	0	0	0
Access to Food, Water, Shelter, Medications	0	0	0
Verbal, Mental, Physical Abuse	1	0	0
Misappropriation of resources / funds	2	0	0
Inappropriate isolation, seclusion, restraints	0	0	0
Lack of prompt, adequate treatment	1	1	0
Access to adaptive aids	0	0	0
Other:	1	0	0

Summary of Unmet Needs/Health and Safety Concerns: The above findings suggest that most unmet needs were health-related. Findings also suggest that most health/safety concerns involved physical dangers in the residence. It also appears that most issues were resolved with the provision of additional information from the CMOs. All unmet needs and health/safety concerns were resolved at the end of the review process.

Appendix E

The Quality Characteristics, and How the Reviewers Determine Their Presence

MetaStar reviewers developed a list of seven quality characteristics that CMO processes and procedures need to have to produce performance measure data that is accurate, reliable, and free from bias. This appendix briefly describes each of these characteristics and what the reviewers look for to find them.

Characteristic 1: Correctly Collecting and Entering Data

Processes and procedures have this characteristic when they include steps to ensure that staff knows how to properly collect and enter data and are routinely able to do so. Reviewers look to see that the CMO takes the following steps:

- Provide the same instructions to all staff members who collect and enter data
- Collect data on standard forms
- Establish procedures to ensure that staff reliably and accurately abstracts data from service records
- Establish standard procedures to enter data into electronic files
- Set up electronic edits to catch and stop the entry of incorrect or invalid data
- Establish procedures to accurately transfer electronic data between files and systems

Characteristic 2: Correctly Combining Data from Multiple Sources

Processes and procedures have this characteristic when they include steps that ensure that data from different sources is correctly combined. Reviewers look to see that the CMO takes the following steps:

- Correctly identifies all of the sources from which to combine data
- Establishes technically correct processes to combine data from these sources
- Organizes the combined data so that performance measures can be properly calculated

Characteristic 3: Catching and Avoiding Mistakes in Preparing Data Reports

Processes and procedures have this characteristic when they include steps to catch and avoid mistakes in preparing reports from data. Reviewers look to see that the CMO takes the following steps:

- Establish procedures to check that data used in reports is complete, timely, accurate, and error-free
- Establish procedures to manage production of the actual reports
- Develop any necessary electronic processes (for instance, database queries) using proper methods
- Test any new electronic process before using it

Characteristic 4: Correctly Identifying the Denominator

Processes and procedures have this characteristic when they include steps to ensure that the members of each performance measure denominator have been correctly identified. Reviewers look to see that the CMO takes the following steps:

- Understand the Family Care Program specifications for each performance measure denominator
- Turn those specifications into instructions to collect and enter the data and prepare reports
- Check that those instructions were correctly carried out

Characteristic 5: Correctly Identifying the Numerator

Processes and procedures have this characteristic when they include steps to ensure that the members of each performance measure numerator have been correctly identified. Reviewers look to see that the CMO takes the following steps:

- Understand the Family Care Program specifications for each performance measure numerator
- Turn those specifications into instructions to collect and enter the data and prepare reports
- Check that those instructions were correctly carried out

Characteristic 6: Correctly Calculating the Rates

Processes and procedures have this characteristic when they include steps to ensure that performance measure rates are correctly calculated. Reviewers look to see that the CMO takes the following steps:

- Correctly interprets Family Care performance measure specifications
- If required to do so, correctly calculates performance measure rates using those specifications

Characteristic 7: Documenting Processes and Procedures

Processes and procedures have this characteristic when they are documented in writing. Reviewers look to see that written documentation exists. The documentation may take a number of forms, depending on how the CMO organizes the work. These forms include:

- Standard operating procedures
- Protocols
- Training manuals
- Sign-off sheets
- Logs
- Flow charts
- Work plans
- Data dictionaries